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TRANSFUSION OF UNMODIFIED BLOOD

AN ANALYSIS OF ONE HUNDRED AND SIXTY-FIVE CASES

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The results of 165 transfusions performed by means of the simple technic[1] I described in 1915 have been so encouraging as to warrant a report. This paper will present (1) an analysis of the effects of transfusion on various clinical conditions; (2) a comparison between the use of unmodified and modified blood, and (3) a summary of the results of all the transfusions.

INDICATIONS FOR TRANSFUSION

The indications for transfusion are (1) hemorrhage; (2) diseases of the blood; (3) toxemias; (4) infections; (5) shock, and (6) general debility.

1. *Hemorrhage.*—This is one of the conditions in which blood transfusion is the ideal form of treatment. It serves not only to replace lost blood but also to check actual bleeding. In acute hemorrhages, the results are naturally more brilliant than in less fulminating bleeding.

The diseases in which hemorrhage served as the indication for the transfusion of blood fall into the following nine groups: (*a*) gastric or duodenal ulcer; (*b*) typhoid fever; (*c*) postoperative hemorrhage; (*d*) ectopic gestation; (*e*) uterine hemorrhage; (*f*) ulcerative colitis; (*g*) jaundice; (*h*) hemorrhages associated with blood diseases, and (*i*) miscellaneous cases.

(*a*) Gastric or Duodenal Ulcer: There were seven transfusions done in five cases of gastric or duodenal ulcer. The supposition that, owing to the rise in blood pressure following a transfusion, the bleeding in gastric ulcer will be increased seems to have no basis in point of fact.

All of the patients were in an extremely critical condition. One transfusion was sufficient to check the hemorrhage in four of the five patients, even though they were bleeding at the time the transfusion was performed. Three of the patients made a prompt and striking recovery. They were converted within a comparatively short time from moribund individuals to convalescents. Plans for operation were abandoned because of their return to perfect health. Two of the five patients died. Each received two transfusions. In one the first transfusion checked the hemorrhage and improved his condition to such an extent that an operation with a preliminary transfusion was resorted to. The other patient was given two transfusions, neither of which succeeded in checking the hemorrhage. This was the only true failure in this group of cases.

(*b*) Typhoid Fever: Three transfusions were performed in two cases of typhoid fever because of complicating intestinal hemorrhage. In one of these, a patient of Dr. Evan M. Evans, transfusion of 1,200 c.c. checked the hemorrhage. During a subsequent relapse there was no recurrence of the bleeding, and the patient made a complete recovery. The other patient was on Dr. Libman's service at Mount Sinai Hospital. Although prompt improvement followed the introduction of 800 c.c. of blood, within a few hours she had another profuse hemorrhage. One thousand c.c. of blood were then given, but subsequent profuse hemorrhage proved fatal.

(*c*) Postoperative Hemorrhage: There were four cases of this kind. The hemorrhages followed gastro-enterostomy, cystoscopy and operations for cholecystitis and for osteomyelitis. All the patients were in a very critical condition, but following the introduction of the new blood they promptly made an uneventful recovery. The result in the patient in whom the bleeding followed gastro-enterostomy was very striking. Besides an immediate cessation of bleeding, the wild and increasing delirium entirely disappeared. Abnormal mental states varying from mild delusions to delirium frequently disappear in this way. These mental symptoms are due to anemia, and vanish when the hemoglobin and the number of red cells is increased.

(*d*) Ectopic Gestation: The three patients in this group were so desperately ill that immediate operation was deemed contraindicated. Transfusions changed the condition of all three so that surgical intervention was warranted. The lives of these three women were saved by the preliminary transfusions.

(*e*) Uterine Hemorrhage: Four transfusions were carried out in three cases of uterine hemorrhage. All the patients recovered. Two were saved from impending death. The transfusions were performed before the operation in order to replace the large quantity of blood lost. Two were instances of retained secundines and the third one of chorio-epithelioma. Two transfusions followed by a hysterectomy (by Dr. L. Druskin) were performed on the last patient referred to. She then made an uninterrupted recovery.

(*f*) Ulcerative Colitis: Three patients on whom six transfusions were performed had ulcerative colitis. All were greatly improved not only as regards their blood but in strength and appetite as well. In two the local condition at once began to respond to treatment. The third, in spite of three transfusions with attendant improvement in the general condition, obstinately

1. Unger, L. J.: A New Method of Syringe Transfusion, THE JOURNAL A. M. A., Feb. 13, 1915, p. 582; Recent Simplifications of the Syringe Method of Transfusion, Sept. 18, 1915, p. 1029.

resisted all local treatment. Transfusion for ulcerative colitis is of benefit, by increasing the patient's vitality and by rendering the local condition in the intestine more responsive to treatment. Repeated transfusions are usually necessary in this disease.

(*g*) Jaundice: Unfortunately this series does not include this condition. Transfusion should, however, be employed in cases of jaundice both to check active bleeding and as a prophylactic measure previous to operation when the coagulation time is considerably prolonged.

(*h*) Hemorrhage Associated with Blood Diseases: These cases are fully discussed under the general heading of diseases of the blood. In twenty-three the transfusions were given to check hemorrhage accompanying blood diseases. In eighteen it succeeded, while in five it failed. Four of these failures were in purpura hemorrhagica, and one in a case of melena neonatorum in which the patient was moribund. In four cases of leukemia, not included in the foregoing number, the bleeding was incidental, and transfusion was given not to check hemorrhage but for the underlying blood condition.

(*i*) Miscellaneous Cases: This group includes four cases and eleven transfusions. One patient had hematemeses of unknown origin. Neither an operation nor a subsequent necropsy cleared up the diagnosis. Two had intestinal hemorrhage of unknown etiology. The fourth bled from multiple hereditary telangiectases. Some of these transfusions were life saving in character. In all, bleeding ultimately recurred, and repeated transfusions were necessary.

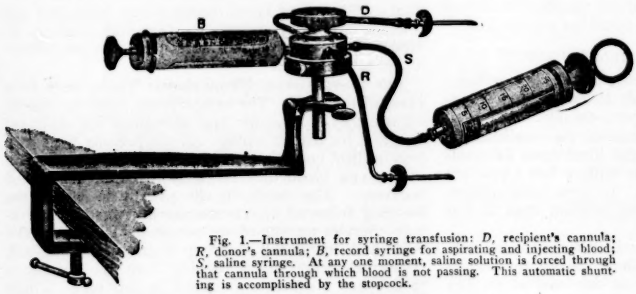

Fig. 1.—Instrument for syringe transfusion: *D*, recipient's cannula; *R*, donor's cannula; *B*, record syringe for aspirating and injecting blood; *S*, saline syringe. At any one moment, saline solution is forced through that cannula through which blood is not passing. This automatic shunting is accomplished by the stopcock.

Summary: Sixty-two transfusions were done in forty-seven cases of hemorrhage. Twenty-four patients had acute or chronic hemorrhage. Nineteen, or 79 per cent., of these, recovered — twelve because of transfusion alone, seven as a result of transfusion and operation. In the latter cases the surgeon was unwilling to attempt any operative measures without a preliminary transfusion. In fifteen, or 62 per cent., the transfusion was a life-saving procedure.

Eighteen of the twenty-three patients with hemorrhage associated with blood diseases recovered. In fifteen, or 65 per cent., transfusion was a life-saving measure.

2. *Diseases of the Blood.*—The clinical conditions were: (*a*) secondary anemia; (*b*) pernicious anemia; (*c*) hemophilia; (*d*) purpura hemorrhagica; (*e*) leukemia; (*f*) bleeding of the new-born, and (*g*) miscellaneous (Banti's disease, von Jaksch's anemia and Henoch's purpura).

(*a*) Secondary Anemia: In one patient the anemia followed malaria; in another (an infant) it was associated with malnutrition. Both patients responded promptly, and made a perfect recovery.

(*b*) Pernicious Anemia: Twenty-three transfusions were performed in fifteen cases of pernicious anemia. The lives of five were saved as a direct result of the transfusions; five patients were greatly improved; the remaining five died within a comparatively short time. Some of these cases could not be followed sufficiently long to pass judgment on the length of time for which the patients were benefited. As a result of repeated transfusion, two have done well for a period of about two years, and another for a period of eight months. A fourth died after a remission lasting six months.

The results of transfusion in pernicious anemia are superior to those achieved by any other mode of therapy. Frequently it acts as a life-saving measure by initiating the onset of a remission. There is no evidence, however, to show that the disease can be permanently cured in this way. Nevertheless, by repeated transfusions, remissions can be effected and the lives of some patients made useful for years. In such cases, if possible, the same donor should successively be employed. The amount of blood does not seem to be the determining cause of a remission. Small amounts have as often been of value as large amounts. When transfusion is successful, the marked increase in strength and appetite is very striking. It will relieve the anemia and the symptoms secondary to it—dyspnea, palpitation, mental symptoms, etc. In no instance did it lead to the secretion of hydrochloric acid by the stomach.

If transfusion is repeated because the first one failed to bring on a remission, different donors should be employed until, if possible, the desired effect is achieved. In such cases, subsequent transfusion should be resorted to, however, before all that has been gained by the previous one has been lost. In certain cases, even this procedure is of no avail.

(*c*) Hemophilia: Eight transfusions were performed in seven cases of hemophilia. All the patients recovered. Five transfusions were life-saving measures. The bleeding was controlled by one transfusion in all but one case. This child, who was bleeding from a lacerated wound of the tongue, received an unmodified blood transfusion which controlled the hemorrhage for four days. A transfusion of citrated blood was then given, but did not control the bleeding. Within a week, two whole blood transfusions were performed, and these checked the hemorrhage. Two of our patients returned months later because of fresh hemorrhages.

Transfusion does not permanently cure the disease hemophilia. It is, however, practically a specific for the bleeding of hemophilia. It will succeed when other measures fail. Five of the patients were treated unsuccessfully with thromboplastin (Squibb), coagulen (Ciba), epinephrin, astringent solutions, citrated blood, subcutaneous injections of whole blood, and iodoform gauze packing. In four of the cases thus treated,

bleeding was stopped by one unmodified blood transfusion, while in one case two transfusions were required. In this connection it must, however, be remembered that transfusion is resorted to only in cases in which other measures have failed. Valuable time should not be wasted in attempts to control bleeding by these methods when we have at our command a specific that will not only control the hemorrhage but also replace the lost blood. The danger of delay is illustrated by the following case:

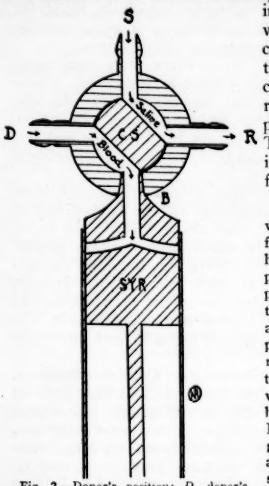

Fig. 2.—Donor's position: *D*, donor's outlet; *B*, blood outlet; *SYR*, blood syringe. Blood passes from donor's vein through *D*, and out at *B* into *SYR*. *S*, saline outlet; *R*, recipient's outlet. Saline solution is forced from saline syringe through *S*, out at *R*, into recipient's vein. *C S*, central stopper (rotates through an arc of 90 degrees).

A child, aged 4 years, was known from his family history to be a hemophiliac. For a period of eleven days prior to being admitted to Dr. Koplik's service at Mount Sinai Hospital, packing with various astringent solutions and also coagulen were used to check bleeding from the nose. By this time the hemoglobin was 25 per cent., and the patient was in such a desperate condition that death seemed imminent. A transfusion of 400 c.c. of whole blood immediately checked the hemorrhage, and raised the hemoglobin to 50 per cent. Eight months later when his nose again began to bleed, it was immediately packed with gauze soaked in thromboplastin and a transfusion at once performed. The hemorrhage was controlled before there was any great loss of blood.

(*d*) Purpura Hemorrhagica: Purpura hemorrhagica is a condition that one would expect to be favorably influenced by blood transfusion. The results of the six cases in this series were not, however, as good as we should hope for. In two of the cases the bleeding was controlled, in one it was not at all affected (epistaxis), and in three death ensued.

In the three fatal cases, the patients were in extremely poor condition and had the severest manifestations of purpura. All three had numerous petechiae, purpuric spots, hematomas and active bleeding, such as from the gums, nose, kidney and vagina. They all showed typical findings of purpura hemorrhagica—a secondary anemia, diminished blood platelet count, positive capillary resistance test, normal coagulation time, prolonged bleeding time, and positive puncture test. In one case the bleeding time was more than an hour; at this point the test was discontinued and the bleeding had to be controlled by pressure.

The paradoxical finding in purpura of a diminished platelet count with a normal coagulation time has recently been shown by Dr. Alfred F. Hess to be only apparent.[2] As a matter of fact, purpuric blood actually has a normal amount of blood platelet material. This material exists in two forms — the visible platelets, and platelets that are in solution in the plasma. He believes that purpura hemorrhagica is caused by a toxin which not only dissolves blood platelets but may also injure the blood vessel walls, bringing about the other manifestations of the disease. Since in certain hemolytic diseases the toxin is thought to be associated with the spleen, he has suggested that in purpura, after preliminary transfusion, splenectomy be performed. This suggestion gains added force when we remember that following splenectomy there is an increase in blood platelets. In view of the marked fatality of some forms of this disease and the rather discouraging result from transfusion alone, or any other form of therapy in this type, this suggestion ought to be given a trial.

(*e*) Leukemia: In six cases of acute lymphatic leukemia, thirteen transfusions were performed. Three cases were practically counterparts of one another, and occurred in adults. These patients were bleeding from a mucous membrane, and had petechial and purpuric spots, fever, marked secondary anemia, a typical leukemic white count, and negative blood cultures. One had enlarged glands, and two an enlarged spleen. The transfusions in all these cases raised the hemoglobin; increased the number of red blood cells; diminished the number of white cells, leaving the differential count practically unchanged; lowered the temperature; improved the general condition, and stopped the hemorrhages. But in all three, relapse soon occurred, bleeding recommenced, and the result was fatal.

One of these patients, who came from Dr. Alfred Meyer's service at Mount Sinai Hospital, was given a "substitutive transfusion." A phlebotomy of 500 c.c. was immediately followed by a transfusion of 1,000 c.c. A second phlebotomy of 600 c.c. was followed by a second transfusion of 1,000 c.c. from another donor. The benefit lasted for six days, when he became rapidly worse and died.

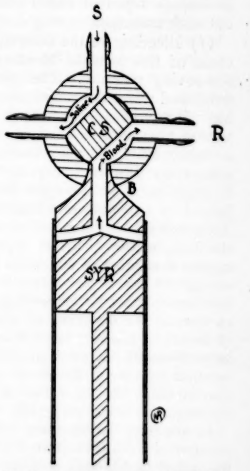

Fig. 3.—Recipient's position; *SYR*, blood syringe; *B*, blood outlet; *R*, recipient's outlet. Blood is forced out of *SYR* through *B*, out at *R*, into recipient's vein. *S*, saline outlet; *D*, donor's outlet. Saline solution is forced from saline syringe through *S* out at *D* into donor's vein. *C S*, central stopper.

The other three cases were in children with subleukemic leukemia. These patients had fever, a profound anemia with a normal or diminished total number of leukocytes, but a high percentage of lymphocytes. In one patient an attempt was made to influence the course of the disease by repeated transfusions. After each of eight transfusions, his general condition and anemia were

2. Hess, A. F.: Proc. Soc. Exper. Biol. and Med., 1917, **14**, 96.

improved. Soon, however, it became evident that no permanent impression on the disease was being made, but that it was merely being prolonged. I wish to emphasize the fact that one other patient was seen early in the disease, before the diagnosis of leukemia was made. The transfusions were given to overcome marked anemia. Although repeated transfusions sustained the hemoglobin, the white count became typical of leukemia. It is evident, therefore, that in acute lymphatic leukemia only a temporarily favorable

TABLE 1.—RESULTS OF TRANSFUSION FOR HEMORRHAGE

Indication	Number of Transfusions	Number of Cases	Recoveries (Hemorrhage Checked)		Deaths	
			Prognosis Bad; Life Saved	Prognosis Not Bad	Temporary Improvement	No Improvement
Gastric ulcer	7	5	3	0	1	1
Typhoid fever	3	2	1	0	0	1
Postoperative hemorrhage	4	4	4	0	0	0
Ulcerative colitis	6	3	0	3	0	0
Hemorrhage with blood diseases	24	23	15	3	2	3*
Ectopic gestation	3	3	3	0	0	0
Uterine hemorrhage	4	3	2	1	0	0
Miscellaneous cases	11	4	2	0	1	1
	62	47	30	7	4	6

* One of these patients is still alive, but the transfusion did not entirely check the hemorrhage.

effect can be secured by transfusion, even though we withdraw a large amount of blood by phlebotomy and make use of a massive transfusion from two donors, or employ repeated transfusions, in spite of carrying out such transfusions very early in the disease.

(*f*) Bleeding of the New-Born: In nine of the ten cases of this kind of bleeding, transfusion proved a life-saving measure. The one patient who died was moribund when the transfusion was started. In bleeding of the new-born, transfusion is a specific. An almost exsanguinated infant, too weak to cry and in a dying state, is immediately transformed into an apparently healthy, rosy and crying baby. As in hemophilia, it will save the lives of those who are not helped by subcutaneous injections of serum or blood. Temporizing by using less effective measures may cost the baby's life. This is especially true in cases of melena neonatorum, which are the most serious because we do not know just when the hemorrhage began or how much internal hemorrhage is taking place. Just as soon as the diagnosis of bleeding from the stomach or bowel of the new-born is made, transfusion should be performed. In cases of melena it is well to remember that because of the blood in the intestine, the stools may be tarry for one or two days after the transfusion, although the hemorrhage has stopped.

In one case the bleeding followed circumcision, and another patient bled from the cord. Eight bled from the bowel in addition to other hemorrhages from such sources as the stomach, kidney, vagina, hard palate or skin. The ages of the patients with melena varied from 32 hours to 6 days. The amount transfused varied from 80 to 150 c.c. No untoward reaction followed any of these transfusions. In every case the median basilic vein was used for the introduction of the blood. An incision from one-fourth to three-eighths inch long directly over the vein is sufficient even in the youngest child. The superior longitudinal sinus was not selected because of possible dangers associated with its use, and because the median basilic vein affords a comparatively simple approach. If the inferior wall of the superior longitudinal sinus is accidentally perforated, there is real danger of injecting blood on the brain or of active hemorrhage occurring, especially as these patients have a hemorrhagic tendency. Using this route for aspirating blood for examination (syphilis, bacteremia) is quite another matter, particularly in nonhemorrhagic cases.

(*g*) Miscellaneous Cases: There were four cases of Banti's disease. All of these patients died. There was one patient with von Jaksch's anemia who was greatly improved after the transfusion, but whose ultimate welfare could be not be followed, and one with Henoch's purpura, whose symptoms were relieved by transfusion.

Summary: In pernicious anemia, transfusion is of value and to be recommended, but can be expected to produce remissions in only about half of the cases. In hemophilia it can be relied on to stop the hemorrhage, but in no way to affect the course of the disease. In purpura it is much less reliable; in fact, recovery followed in only two of our six patients. In acute leukemia it is of but temporary benefit. In bleeding of the new-born it is a specific and essentially a life-saving measure.

3. *Toxemia.*—Transfusions have long been employed in a limited number of types of toxemia. It is in this group that we ought to enlarge the indications, especially in toxemias associated with acute infections, such as pneumonia and typhoid fever. A remarkable and unexpected result of transfusion in a case of toxemia of pregnancy ought to be followed by further attempts at combating this disease in this way. Transfusions were done for toxemias associated with: (*a*) pneumonia; (*b*) pyogenic infections; (*c*) coal gas poisoning; (*d*) morphin poisoning; (*e*) uremia; (*f*) scurvy, and (*g*) toxemia of pregnancy.

(*a*) Pneumonia: Four children with bronchopneumonia were transfused because of extreme toxemia. They were all in very poor condition at the time, but responded favorably and progressed to recovery.

TABLE 2.—RESULTS OF TRANSFUSION FOR BLOOD DISEASES

Indication	Number of Transfusions	Number of Cases	Recoveries		Deaths	
			Bad Prognosis; Life Saved	Prognosis Not Bad	Temporary Improvement	No Improvement
Secondary anemia	2	2	1	1	0	0
Pernicious anemia	22	15	5	5	4	1
Hemophilia	8	7	5	2	0	0
Purpura hemorrhagica	6	6	1	1	2	2
Leukemia	13	6	0	1	5	0
Bleeding of new-born	10	10	9	0	0	1
Miscellaneous	6	6	0	2	4	0
Total	68	52	21	12	15	4

(*b*) Pyogenic Infections with Extreme Toxemia: There were four patients: two had empyema pleurae, one had salpingitis and peritonitis, and one a subphrenic abscess. All were extremely toxic and died following temporary improvement.

(*c*) Coal Gas Poisoning: In the sole case of coal gas poisoning in this series, the patient had beginning pulmonary edema, and was moribund when seen. In fact, in order to keep him alive until transfusion could be performed, artificial respiration was employed. Although transfusion was preceded by phlebotomy, the result was fatal.

(*d*) Morphin Poisoning: Although no case of this type was treated, it is interesting to note that the effects of morphin given previous to some of the transfusions seemed to be lessened immediately thereafter.

(*e*) Uremia: All three patients with uremia were in a hopeless condition. Transfusion was followed by a transitory improvement in the course of the disease. Although this series includes no transfusions for diabetic coma, the results of others have been unsatisfactory.

(*f*) Scurvy: Although many consider this condition a deficiency disease, others believe it is due to a toxin, and therefore it has been included in this group. The one patient had subacute scurvy. Improvement was immediate and marked. A pulse of 180 and respiration of 60 (cardiorespiratory syndrome of Hess) were changed to 120 and 40, respectively. The inability to gain in weight that is characteristic of scurvy was overcome.

(*g*) Toxemia of Pregnancy: The one case of this type, a patient of Dr. Rongy, was deeply jaundiced, comatose and moribund. The toxemia was hepatic in origin. Transfusion was preceded by phlebotomy. The coma soon disappeared, but in spite of the fact that for a time the outcome seemed dubious, she made a complete recovery.

4. *Infections.*—These cases may be divided into two groups: (*a*) localized pyogenic infections, and (*b*) bacteremia.

(*a*) Localized Pyogenic Infections: In an effort to increase the patients' vitality and to overcome the infection, five patients with intractable suppurative processes were transfused. Three were greatly improved and went on to recovery. They suffered from pelvic abscess, multiple abscesses of the kidney, and pyarthrosis. All were also given surgical treatment. Two patients died, one of gas bacillus infection of the leg and one of pylephlebitis. After each of the five transfusions given the latter patient, there was a period of temporary improvement.

(*b*) Bacteremia: Eleven transfusions were given ten patients with bacteremia. There were two cases of infective endocarditis, one of bacteremia following cholecystectomy, and seven of puerperal sepsis. In all there was an improvement of the general condition, and in some a cessation, for a short period, of the chills. The temporary benefit was followed by death. Perhaps, however, the bacteremia could be combated in some instances if immune donors were used in an attempt to establish a passive immunity.

5. *Shock.*—Transfusions were performed in three cases because of shock. Two were postoperative and one traumatic in origin.

One of these patients had been run over by a heavy automobile truck, sustaining a compound fracture of the humerus. As there was a possibility of internal hemorrhage from a ruptured spleen, transfusion and exploratory laparotomy were performed. It was then evident that the signs were those of profound shock and not hemorrhage. The patient made a complete and remarkable recovery. The second patient was transfused immediately after a splenectomy (Dr. Howard Lilienthal), and recovered. In the third case, shock was also postoperative in origin. Here, however, various drugs as well as an intravenous infusion of saline solution were employed before transfusion was resorted to. After a brief rally, the patient died.

It is interesting to note that the two patients who recovered were transfused almost immediately after shock became evident. It is possible that the time element is a deciding factor.

6. *General Debility.*—Transfusion as a supporting measure was employed (*a*) preliminary to operations, and (*b*) in debilitating diseases.

(*a*) Preliminary to Operations: There were six patients with carcinoma with such a severe grade of anemia that they were considered poor operative risks. Five had carcinoma of the stomach, and one carcinoma of the head of the pancreas. Four survived the operations, and two died. There is no doubt that transfusion lessened the postoperative mortality.

(*b*) Debilitating Conditions: The patients included in the preceding group suffered from debilitating diseases, but since they were in fair condition, operation was permissible. There were, however, fourteen other similar patients. Six had carcinoma, but were in such desperate straits that operation could not be thought of. They were transfused merely to improve their general condition and prolong their lives. Five were transfused as measures of last resort. All were moribund. The diagnoses were ulcerative colitis, syphilitic stricture of the jejunum, acute insufficiency of the liver, and pemphigus (two cases). Patients with interstitial nephritis, acute parenchymatous nephritis, and cirrhosis of the liver were improved by the transfusion, and were able to leave the hospital.

TECHNIC

All of the 165 transfusions were performed by the method previously reported.[1] This method utilizes the instrument described in the accompanying illustrations. The mechanical principle involved is the establishment of two channels by means of which a record syringe is automatically connected alternately with a vein of the donor and then with one of the recipient. At the same time that the record syringe is connected with the donor for the aspiration of blood, a syringe with saline solution is connected with the recipient, and vice versa. It is this immediate and continued flushing with salt solution of the channel through which blood is not passing that insures freedom from clotting.

The technic is as follows: Alongside the instrument, which has been fixed to a table, the arms of the patient and the donor are placed. The tubes leading from the instrument are connected to the cannulas after the latter have been inserted through the skin into the recipient's and the donor's veins. A record syringe is then inserted into the instrument, and blood is aspirated. When the syringe is filled, the stopcock is turned and the blood is injected. A continuous stream of saline solution is forced in a direction opposite to the flow of blood. This procedure is continued until the desired amount is transfused. By means of a spray, a stream of ether is played on the barrel of the record syringe while it is being filled with and emptied of blood in order to prevent clotting. In this way only one record syringe is required, regardless of the amount transfused.

COMPARISON BETWEEN THE USE OF UNMODIFIED AND MODIFIED BLOOD

One of the points of active interest in connection with transfusion is that of the relative merits of unmodified blood and of blood that has been modified by means of small amounts of sodium citrate. As

is well known, the latter method has recently gained considerable vogue, and, indeed, by some is claimed to render other methods of transfusion unnecessary. This is the view that has been recently stated by Bernheim.[3] From my point of view, transfusion of unmodified blood cannot be so lightly set aside. It has been shown recently by Novy[4] and DeKruif that blood acquires toxic properties in direct proportion to the path it travels toward coagulation. Even though it does not absolutely coagulate, processes take place within it, as soon as it is poured forth from the vessels, that change its nature and render it less suitable as a body fluid. These studies are new and as yet incompletely worked out. They seem to show, however, what *a priori* would seem to be most likely, that from a biologic point of view such a delicate tissue must be altered in the carrying out of a transfusion of citrated blood[5] because of its considerable sojourn outside the body. From a clinical standpoint, this alteration is also evidenced. Frequently chill and fever and occasionally vomiting follows transfusion of citrated blood, while whole blood is only occasionally followed by fever, and a chill is the exception.[6] I believe that for diseases in which blood is indicated for itself, that is, when it is required as a tissue, as in the various anemias, there can be no question as to the relative merits of unmodified blood which runs almost from vessel to vessel and of that which has remained for an indefinite length of time outside of the body. The transfusion of unmodified blood is the procedure of choice. It must be admitted, however, that the technic for giving citrated blood is simple, and that therefore in cases of hemorrhage, in which the purpose is not so much to supply normal for pathologic blood as to furnish the impoverished circulation with an adequate supply or to bring about cessation of hemorrhage, citrated blood may serve as a substitute.

SUMMARY OF RESULTS

In all, 165 transfusions were performed on 128 patients. These can be classified according to results as either recoveries or deaths.

1. *Recoveries.*—Seventy-one, or 55 per cent., of the patients recovered. They either had very bad prognoses and their lives were saved, or they had better prognoses and were definitely helped. The lives of forty-four, or 34 per cent., were saved by the transfusion. The vast majority of these had hemorrhages or diseases of the blood.

(*a*) Cases in Which Life Was Saved:[7] Bleeding gastric or duodenal ulcer, 3; intestinal hemorrhage in typhoid fever, 1; postoperative hemorrhage, 4; ectopic gestation, 3; uterine hemorrhage, 2; intestinal hemorrhage of unknown origin, 2; profound secondary anemia following malaria, 1; pernicious anemia, 5; hemophilia, 5; purpura hemorrhagica, 1; bleeding of the new-born, 9; toxemia in pneumonia, 4; scurvy, 1; toxemia of pregnancy, 1; shock, 2.

(*b*) Cases in Which There Was Definite Benefit, but in Which the Transfusion Was Not a Life Saving Procedure: Ulcerative colitis, 3; uterine hemorrhage, 1; profound secondary anemia, 1; pernicious anemia, 5; hemophilia, 2; purpura hemorrhagica, 2; acute lymphatic leukemia, 1; von Jaksch's anemia, 1; Henoch's purpura, 1; profound anemia secondary to chronic suppuration, 3; carcinoma of stomach, 4; acute parenchymatous nephritis, 1; chronic interstitial nephritis, 1; hepatic cirrhosis, 1.

2. *Deaths.*—In eight patients there was no improvement, although from the nature of the disease a good result might have been expected. The deaths of the others were due to the underlying disease. Some were in such a condition that although little was expected of the transfusion, it was done as a measure of last resort. In the others, death was preceded by temporary improvement.

(*a*) Cases in Which a Good Result Might Have Been Expected: Bleeding gastric ulcer, 1; intestinal hemorrhage from typhoid fever, 1; hemorrhage from multiple hereditary telangiectases, 1; pernicious anemia, 1; purpura hemorrhagica, 2; bleeding of the new-born, 1; shock, 1.

(*b*) Cases in Which Death Was Due to the Underlying Disease: Gastric ulcer (the patient died following an extensive operation), 1; hematemeses of unknown etiology, 1; pernicious anemia, 4; purpura hemorrhagica, 1; acute leukemia, 5; Banti's disease, 4; empyema of the thorax, 2; acute salpingitis, 1; subphrenic abscess, 1; uremia, 3; coal gas poisoning, 1; pylephlebitis, 1; gas bacillus infection, 1; infective endocarditis, 2; bacteremia following cholecystectomy, 1; puerperal sepsis, 7; carcinoma of stomach, 5; carcinoma of colon, 2; carcinoma of the head of the pancreas, 1; ulcerative colitis, 1; pemphigus, 2; syphilitic stricture of the jejunum, 1; acute hepatic insufficiency, 1.

TABLE 3.—SUMMARY OF RESULTS OF TRANSFUSION

Indication	Number of Transfusions	Number of Cases	Recoveries		Deaths	
			Bad Prognosis; Life Saved	Prognosis Not Bad	Temporary Improvement	No Improvement
Hemorrhage	38	24	15	4	2	3
Blood diseases	68	52	21	12	15	4*
Toxemias	14	14	6	0	8	0
Infections	20	15	0	3	12	0
Shock	3	3	2	0	0	1
General debility	22	20	0	7	13	0
Total	165	128	44	26	50	8

* Although one of these patients did not die, the case is grouped here because little improvement followed transfusion.

CONCLUSIONS

1. The best results of transfusion were obtained in hemorrhage, diseases of the blood, toxemias and shock. In 88 per cent. of the cases of acute hemorrhage, bleeding was stopped by one transfusion. In pernicious anemia, remissions can be initiated. Repeated transfusions frequently bring on repeated remissions. If no remission results, transfusion with a different donor should be performed. For the hemorrhage of hemophilia, transfusion is practically a specific. It is dangerous to delay too long with palliative measures if active bleeding is present. In purpura, transfusion gives only moderately good results. In the severe cases, it would seem advisable to carry out the suggestion of splenectomy with preliminary transfusions. All attempts to influence acute leukemia failed. In bleeding of the new-born, transfusion is a specific. Especially in cases of melena, temporizing by using other methods is contraindicated. The median basilic vein can be used regardless of the baby's age, and is the route of choice.

3. Bernheim, B. M.: Sodium Citrate Blood Transfusion: A Comparison, THE JOURNAL A. M. A., Aug. 4, 1917, p. 359.

4. Novy, F. G., and DeKruif, P. H.: Anaphylatoxin and Anaphylaxis, THE JOURNAL A. M. A., May 26, 1917, p. 1524.

5. Lewisohn, Richard: Med. Rec., New York, Jan. 23, 1915. Weil, Richard: Sodium Citrate in the Transfusion of Blood, THE JOURNAL A. M. A., Jan. 30, 1915, p. 425.

6. Of all the patients in this series, eleven had febrile reactions and two had chills. In two other cases, reactions were anaphylactic in nature, while in still another in which tests had been omitted it was due to hemolysis. Reference may also be made to Libman and Ottenberg: Am. Jour. Med. Sc., 1915, **150**, 36.

7. The figures refer to the number of patients treated by transfusion.

Transfusion, although employed in a comparatively small number of cases, has yielded encouraging results in toxemia associated with acute infections (e. g., pneumonia), toxemia of pregnancy, scurvy and shock. It seems to overcome shock if employed at the onset of the symptoms.

2. Transfusion is often of assistance in overcoming intractable suppurative processes and causing a marked increase in the vitality of the patient. In bacteremias, it has had practically no success. It is possible, however, that if immune donors were used the results might be better. Transfusion given preliminary to an operation will often so improve the patient's condition that the surgeon is justified in risking an operation. It will prolong the life of a patient suffering with a debilitating condition.

3. The syringe cannula method (requiring only one syringe) has proved a simple, efficient and dependable one for giving whole unmodified blood. The giving of unmodified blood is the method of choice when blood is required as a tissue (as in various anemias). When it is required to replenish impoverished circulation, citrated blood can serve as a substitute.

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THE BIOLOGIC CLASSIFICATION IN PNEUMOCOCCIC INFECTIONS*

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This report is a summary of our results in classifying pneumococci according to their biologic differences. The material was obtained from patients admitted to the Allegheny General Hospital and from patients in Pittsburgh and its suburbs. The technic used was identical with that developed at the Rockefeller Institute and reported by Dochez and Gillespie,[1] Cole,[2] Avery[3] and others. The pneumococci were isolated from the sputum. In many instances, blood cultures were also taken and, when other conditions were present or developed later, such as meningitis, empyema, lung abscess, acute otitis media and mastoiditis, cultures were taken from them. In several necropsies in which pneumonia was encountered, cultures were taken from the lung, the heart's blood and the obvious accompanying lesions. The purpose of these various cultures was to determine whether the cultures of pneumococci from various lesions in the body corresponded in regard to their biologic classification.

Five of the patients suffering from pneumonia of Group I were treated with the corresponding antiserum. Treatment was instituted late in four cases; one of these patients recovered. Two of the patients developed a meningitis and received the antiserum both intravenously and intrathecally. Blood cultures taken twenty-four hours after the administration of the serum were positive three times in one patient and twice in the other. Cultures of the spinal fluid after the administration of the serum were also positive. The other recovery occurred in a laboratory worker accidentally infected while working with a very virulent organism of Group I. The onset was violent; and despite a rather hopeless outlook, the disease yielded in a decisive and gratifying manner to the early administration of the antiserum.

The accompanying table shows the number of patients studied (including the subjects of twelve necropsies), the incidence of the various groups of pneumococci, the mortality, etc. Those included in the group of "unclassified, streptococcus, etc." are those in whom the pneumococcus was not obtained or identified, or those in whom the culture proved to be streptococci.

INCIDENCE AND MORTALITY OF PNEUMOCOCCI

Groups	Incidence		Number of Deaths	Mortality, per Cent.	Remarks
	Number	Per Cent.			
I	41	41.4	15	36.5	5 treated with serum (3D.-2R).
II	29	29.3	10	34.5	3 Subgroup II — 2 mastoid — recovered
III	6	6.0	4	66.6	
IV	23	23.2	6	26.0	
Unclassified, streptococcus, etc.	13	....	3	23.0	
Total	112				
Total without unclassified	99	....	35	35.3	

The incidence of the various groups of pneumococci apparently agrees quite closely with that found elsewhere (Cole[2]). There is some variation in the mortality, that in Group IV being high, but it is not great enough to preclude being evened up in a larger series.

Of ten blood cultures taken from those suffering from Group I infections, nine were positive. Of six taken in Group II, two were positive. The one taken in Group III was positive, and the three taken in Group IV were negative. Out of the nine Group I patients yielding positive blood cultures, six died, a mortality of 66.6 per cent. Three were treated with antiserum, one of whom recovered. In two patients of Group II yielding positive blood cultures, one died, and in four yielding negative cultures, three died. The one Group III patient yielding a positive blood culture died. Of the three in Group IV yielding negative cultures, one died. Of the twelve patients in all groups yielding positive blood cutures, eight died, a mortality of 66.6 per cent. Of eight cultures taken from the heart's blood at necropsy, six were positive, three of them belonging to Group I and one to each of the other three groups, and two were negative, belonging to Group II.

Cultures from ten pleural effusions yielded pneumococci classified thus: Group I, four times; Group II, four times, and Group IV, twice. Only one patient, whose infection was due to an organism of Group I, died.

In ten instances of meningitis, seven belonged to Group I, two to Group II, and one to Group IV.

From twenty-one patients, including the subjects of twelve necropsies, cultures were made from two or more sources. In all instances, the cultures of pneumococci thus obtained from each patient belonged to the same group.

* From the William H. Singer Memorial Research Laboratory.

1. Dochez, A. R., and Gillespie, L. J.: A Biologic Classification of Pneumococci by Means of Immunity Reactions, THE JOURNAL A. M. A., Sept. 6, 1913, p. 727.
2. Cole, R. I.: New York Med. Jour., 1915, **101**, 1, 58.
3. Avery, O. T.: Jour. Exper. Med., 1915, **22**, 804.

In the course of our studies we observed a recurrence, or second infection, in two patients. The one had as his first infection a member of Group IV, and the other a member of Group II. In their second attack both suffered from infections belonging to Group I. The one was exposed to an infection with a Group I organism, because on two occasions of several days' duration he had occupied a bed adjacent to a patient suffering from an infection belonging to Group I. As to a similar exposure of the other, we are not certain, though he was in the same ward with patients infected with the other groups of pneumococci. Both recovered from both attacks.

SUMMARY

The foregoing report shows that the incidence of the various groups of pneumococci occurs in a similar ratio to that in the pneumonias elsewhere. The mortality is fairly comparable. When blood cultures are taken, those yielding positive results are more serious, though one would probably obtain many more positive cultures if they were taken daily. It would seem that most of the instances of meningitis are due to organisms of Group I. When numerous cultures are taken from several sources in the patient, these cultures invariably belong to a single group.

A UNIFORM AND GENERALLY APPLICABLE SYSTEM FOR REPORTING SURGICAL END-RESULTS

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The foundation of future progress in surgery must consist largely of a comprehensive understanding of the successes and failures of the past. In view of the fact that several million operations have been performed in this country alone during recent years, we should now have abundant data about the end-results of operations frequently performed. The lack of available end-result data in many important fields of surgery is little short of amazing.

A few years ago, the medical director of one of the life insurance companies undertook to determine the insurability of persons recovering from the commoner types of surgical kidneys. Out of 100 surgeons consulted, only eight were able to furnish data of any value on the subject, and the medical director was obliged to conclude that very few surgeons could make a definite statement, based on their own work, concerning the ultimate effect of their kidney operations on the comfort and duration of life of their patients.

At the lowest estimate, between 20,000 and 30,000 operations for exophthalmic goiter have been performed in this country during the past ten years. Yet, except for some fragmentary data on the subject of the operative mortality and general trend of the end-results obtained in several clinics in which special skill has been developed in handling these cases, the surgical profession itself is in almost complete ignorance as to the actual results obtained through this large number of operations for exophthalmic goiter. During the same period, there have been several hundred thousand operations on the gallbladder and ducts; yet up to June, 1917, surgeons have had no really definite data to show the frequency of recurrences after these operations. No one knows the relative proportion of recurrences following cholecystostomy and cholecystectomy, and today the whole question of cholecystostomy versus cholecystectomy is debatable because the data to settle the question have not been collected. As a matter of fact, much of the literature of the past few years has been based on only the most meager and indefinite data. A similar lack of adequate end-result knowledge might be cited in many other fields of surgery.

Several reasons have been assigned for this lack of knowledge, such as the difficulty of keeping track of patients and the time and labor required to ascertain and record the results. My own end-result studies, carried on through a period of ten years, have convinced me that the chief reason for our present-day lack of end-result knowledge is that surgeons have not as yet devised a uniform and satisfactory system of reporting the data they have collected. Surgical literature is full of communications dealing in a general way with the subject of end-results, in which it is evident that authors possess considerable data which they despair of presenting in other than the most general terms.

Some time ago, I found that I had several thousand histories with end-result records extending over fairly adequate periods of time. But whereas these records had been collected with, let us say, one unit of energy on my part, when I came to study any one group of cases, it took several units of time and energy to put the data into form suitable for study and comparison. In some groups, it was quite impossible to classify the results according to the usual standards. Also I found that no two surgeons adopted the same standards in reporting their cases, so that it was impossible to compare small groups from different sources or to combine them into larger series, of greater statistical value.

As a rule, surgeons have attempted to state their end-results in terms such as "cured," "improved," "unimproved" or "dead." The trouble with this system is that in practice it is often quite impossible to assign a given case under any one head. As a typical example of the difficulties encountered, I will cite the following gallbladder case:

> A man, aged 45, had typical gallstone attacks for twenty-five years. A cholecystostomy was performed, Nov. 10, 1908. The ducts were free; 1,675 stones were removed from the gallbladder. Seven years after this operation, the patient told me that he had never had a symptom of his old trouble, and felt ten years younger than he did before the operation. Seven years and five months after the operation, however, he again developed gallstone colics accompanied by jaundice which increased in frequency and severity until, eight years and four months after the first operation, he was again operated on and a large stone removed from the common duct.

It is obvious that this case does not fit under the heading "cured" or, for that matter, in any other group. It is also obvious that the only way to state the end-results of the first operation in this case is to use some statistical method which will give the first operation credit for a cure extending over seven years and five months, after which there was no further benefit from this operation. Thus far, this patient's history has been traced eight years and five months, during 88 per cent. of which time he was cured by the original cholecystostomy.

Similar difficulties occur with greater or less frequency in practically all fields of surgery. In cases of exophthalmic goiter it is practically impossible to state the end-results following operations in the terms usually employed by surgeons reporting end-results. Gallbladder and kidney cases are little, if any, better, and gynecologic cases present similar difficulties. When we seek the reason for the difficulties encountered in trying to state end-results in such simple terms as "cured" and "improved," it is evident that these terms are descriptive of the relative postoperative health at a given period of time only, whereas to give a true description of the postoperative health of the patient, extending over a period of months or years, the element of time must be included in the description. It is as illogical to attempt to measure the postoperative life in terms that ignore the time factor as it would be to attempt to measure a plot of ground in terms of one dimension.

All the major difficulties of presenting the end-results disappear if we tabulate the results in terms of the periods of time for which the patients' histories have been traced after the operation, together with their state of health for the time periods. By this method, the "cured" column becomes "years cured," and the term "years" is added to the other divisions. It is also of advantage to add the headings "years operated" and "years traced," as illustrated in the accompanying table, which shows the results of tabulating 100 gallbladder cases by this method.

A statistical correction should be made for the cases in which the patients die immediately after operation. As their histories are traced up to the time of death, it would be obviously unfair to give them full time in the "years dead" column. The factor for correction here is the proportion of the total postoperative time for which surgeons have been able to trace their patients. On the assumption that they have been traced 80 per cent. of the total postoperative time, a patient dying at operation five years before is given 80 per cent. of this time, or four years, in the "years dead" column.

The advantages of this system of recording end-results are quite obvious. No matter how complicated the postoperative history, it may be readily subdivided and classified into the appropriate periods. It is not necessary for the surgeon to trace each case to the time of reporting his results. If he has lost track of his patients soon after operation, this fact is clearly shown by his figures, and the value of the data may be judged accordingly. Long series of cases may be reported individually, by the use of only a line to a case, so that the postoperative histories of several hundred cases may be detailed on a page or two of a medical journal. To summarize an entire series of cases, it is only necessary to add the figures and strike the averages, and the results show at a glance the mean postoperative prognosis for the disease in question in the hands of the surgeon making the report.

The wealth of information conveyed by data summarized by this method is often surprising. For instance, a glance at the "years operated" column in the accompanying table reveals the fact that the surgeon reporting these cases did a number of cholecystostomies for noncalculous cholecystitis, but that this operation has not been popular with him in recent years. It also shows that lately he has been doing cholecystectomy in similar cases.

In conclusion, I wish to emphasize the fact that the plan for recording end-results as described in the foregoing is almost universally applicable to the summarizing of surgical end-results. If it were generally adopted by surgeons in reporting their results, then data from diverse sources would become available for the compilation of long series of cases and for the numerous comparative studies which are necessary if we are to determine the real factors making for success or failure in our work.

Illuminating Company Building.

END-RESULTS FOLLOWING GALLBLADDER OPERATIONS

Diagnosis	Operation	Operations	Years Operated	Average Years Operated	Years Traced	Average Years Traced	Cured		Improved		Unimproved		Deaths	
							Years	Per Cent.	Years	Per Cent.	Years	Per Cent.	Years	Per Cent.
Gallstones.....	Cholecystostomy	42	190 1/12	4 6/12	121 1/12	2 9/12	87 3/12	72	23 3/12	19	7 4/12	6	3 4/12	3
Gallstones.....	Cholecystectomy	28	87 7/12	3	64 1/12	2 4/12	46 9/12	73	10 9/12	17	1 10/12	3	4 9/12	7
Cholecystitis....	Cholecystostomy	13	88 2/12	6 9/12	51	3 11/12	9 10/12	19	21 2/12	41	20	40	0	0
Cholecystitis....	Cholecystectomy	14	20 11/12	1 6/12	16 8/12	1 2/12	10 3/12	62	3 5/12	20	3	18	0	0
Common duct...	.....	3	5 3/12	1 8/12	5 1/12	1 8/12	1	..	.....	..	.....	..	4 1/12	...
Totals.....	.....	100	392	3 11/12	257 11/12	2 7/12	58 6/12	60	58 6/12	22.6	32 2/12	12.4	12 2/12	5

Production of Vegetable Oils.—The war has made the production of all sorts of fats and oils highly important. Consul Charles L. Hoover at Sao Paulo, Brazil, in *Commerce Reports*, November 21, reports on the development of the vegetable oil industry in his district. Although a great deal of cotton has been raised in the state, until recently no cottonseed oil was produced, all of it used being imported from the United States. The manufacture of the oil has now begun, however, and several factories are in operation, oil of the highest quality being produced. Whereas in 1913 over 2 million pounds of oil was imported, in 1917 only two small shipments were brought in and the exports considerably exceeded the imports. Castor oil is another oil that is now being produced in that state. The castor bean grows wild and has been regarded as something of a pest, as it is hard to eradicate. Modern machinery is being bought in the United States for producing the oil in larger quantities. Linseed oil has heretofore been imported almost exclusively from England and Argentina. Preparations are now being made to produce this oil from the flaxseed, which is being extensively grown. Peanuts are also now being given attention as a source of oil. Several varieties of nuts found in the district are available for their oil. Among these are the cashew nut, the ucuba, which is said to be 60 per cent. vegetable tallow, and the babasu, which also contains 60 per cent. of oil. The babasu nut, it is said, will burn for half an hour if a match is touched to it. Its kernel is like copra, and it is excellent for soap making.

AN UNUSUAL CASE OF ACUTE MYELOGENOUS LEUKEMIA

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The acute types of leukemias are often difficult or impossible of diagnosis. The descriptions of clinical and postmortem findings in acute myelogenous leukemia especially are so rare in the available literature that it was thought for a while that this type did not exist as a pathologic entity. As the case in question was diagnosed definitely only at the postmortem, we have considered the clinical progress of this disease worthy of record.

REPORT OF CASE

History.—Mrs. J. R. H., aged 35, white, domestic, was admitted to the service of Dr. B. A. Ledbetter, Oct. 8, 1916, complaining of "sore mouth and general weakness." There was nothing of significance in the family history. The patient had measles and whooping cough in childhood and typhoid fever one year before admission. She was married and had two children, both living and apparently well. She strenuously denied miscarriages, syphilis and leukorrhea. Until four months before, the patient had been in perfect health, doing housework and suffering no discomforts. About that time she first noticed that her gums were sore and swollen. She went to a dentist and had several teeth extracted. The gums seemed to heal, only again to become inflamed in a few weeks. Since then she had been gradually getting weaker, until a few days prior to admission, when she did not have sufficient strength to leave the bed. A loss of 15 or more pounds in the last month was noted. Her appetite was poor, and her bowels fairly regular. No vomiting nor expectoration of blood occurred. There was no rise in temperature and no pain, except from the teeth, and no cough.

Physical Examination.—The patient was poorly nourished and markedly anemic. The skin was of a sallow tint, dry and inelastic. The glands of the neck were enlarged. The teeth were badly kept, sordes was present, and there was marked pyorrhea. The teeth were loose and decayed, and several were missing. The tongue was dry and coated, and the mucous membranes were markedly anemic. The throat, nose, ears and heart were negative. The lungs showed a roughened breathing at each apex, but neither râles nor dulness. The abdomen was flaccid and relaxed. A large cicatricial scar from an old burn was noticed to the right of the umbilicus. The liver was not palpable. The spleen was much enlarged, extending to the midline and nearly as low as the umbilicus, and was rather hard and firm with a fairly sharp edge. The vaginal and rectal examination revealed nothing abnormal. The extremities and reflexes were negative.

Laboratory Reports.—There was a total leukocyte count of 83,330 per cubic millimeter, and a total erythrocyte count of 2,400,000 per cubic millimeter, with a hemoglobin of 30 per cent., making a color index of 0.62. Examination of the urine revealed a trace of albumin, but sugar, indican and acetone were not present. Microscopically, many fine and coarse granular casts, and a few pus cells were found. Both the original Wassermann test and the modifications were negative. Smears from the teeth revealed the *Endamoeba buccalis* in large numbers. A roentgenogram of the chest revealed very dense glands at the lung roots, with slight infiltration of both upper lobes.

Differential Blood Count: On examining a Wright stained blood smear, we were unable to agree on the type of mononuclear cell predominating. Some of the cells resembled myelocytes and others large lymphocytes. The cell in question was about the size of a myelocyte, but it had a nucleus that nearly filled its entirety, and showed only slight tendency to transition forms, and practically none of polymorphonucleation. The cytoplasm of these cells was finely granular with a marked tendency to basophilic stain. Slides were submitted to such pathologists and hematologists as Drs. Bass, Couret, Duval, Johns, Langford and Weis. The reports were about equally divided between a diagnosis of myelogenous and acute lymphatic leukemia. By a personal letter dated October 16, to Dr. J. D. Weis, Dr. Richard C. Cabot of Boston reported as follows:

"I think the cells in your slides of blood are large lymphocytes. I do not think that they represent the older stem cells, ancestors of red cells and white cells alike, though, as you know, one often gets these stem cells in leukemia. Neither do I believe that they represent neutrophilic myelocytes of the bone marrow series. I think they are the ordinary large lymphocytes of normal blood. I believe the case is one of so-called lymphoid leukemia, without much of any anemia, apparently."

Treatment.—This consisted of stimulation with strychnin, brandy, digitalis and forced nourishment. The patient rapidly became weaker and had a temperature ranging from 99 to 100 F. October 20 (the eleventh day in the ward), we noticed that there was an enlargement of the entire superficial gland chains over the entire body, the individual glands being the size of split peas. October 22, the patient voided and defecated involuntarily and refused all nourishment, and at 4:35 a. m., October 23 (the fifteenth day after admission to the ward), the patient died.

BLOOD FINDINGS

Date	Total Erythrocytic Count	Hemoglobin	Color Index	Total Leukocytic Count	Differential White Cell Blood Count (500 Count)				
					Polymorphonuclear Neutrophils	Polymorphonuclear Eosinophils	Lymphocytes	Myeloblasts	Transitionals Myelocytes
Oct. 9, 1916	2,400,000	30	0.62	83,330	7.8	1	5.2	78.8	7.2
Oct. 14, 1916	.....	..	....	217,707	9.4	0.8	3.6	75	11.2
Oct. 17, 1916	.....	..	....	312,000	4	...	2	84.8	9.2
Oct. 20, 1916	1,984,000	..	....	487,000	8	1	5.2	71.2	14.6
Oct. 22, 1916	1,800,000	25	0.67	716,600	5.8	1.2	8	62	23

Necropsy Report.—The necropsy was held by Dr. C. W. Duval, Oct. 24, 1916, twenty-nine hours postmortem.

Body: The skin was of a light lemon yellow hue, especially marked on the face and neck. The anterior surface from the chin to the pubes was thickly studded with pin point and larger subcutaneous hemorrhages (petechiae). These punctate hemorrhages were most marked over the abdomen, and were bluish black on the abdomen, but of a purple hue in other locations. The superficial lymph nodes in the inguinal, axillary and cervical regions were enlarged and freely movable.

Peritoneal Cavity: The omentum was peppered with large and punctate hemorrhages. The serous covering of the viscera contained numerous petechiae, and the mesentery, more especially that of the small intestine, was diffusely hemorrhagic. There was, however, no free blood in the peritoneal cavity.

Heart: Four warty excrescences were noted on the mitral valve, the larger being approximately the size of a small almond. One of these excrescences in particular had a roughened outer surface, and in places it would appear as though bits had previously broken off.

Lungs: Both organs were voluminous and crepitant throughout.

Spleen: At the upper and lower poles, there were to be seen nodular masses that pushed out far above the general diameter of the spleen. On section, these nodules were found to be well defined areas of infarction (anemic variety). The smaller areas of infarction were surrounded by a well defined zone of hemorrhage. The spleen itself, on section, was coarsely granular and opaque (pyoid), and its surface was grayish red.

Liver: This organ was enlarged, and scattered throughout the parenchyma were numerous opaque nodules embedded in the substance, not sharply defined, and measuring from 2 to 5 cm. in diameter (myeloid tissue).

Pancreas: This organ was firm, distinctly lobulated, and of a lemon yellow color.

Gastro-Intestinal Tract: Throughout the entire tract the mucosa was diffusely hemorrhagic. There was, however, no free blood in the lumen. The mucosa of the ileum was dark slate gray, while the mucosa of the other portions of the small intestine was light purplish red. The lymph follicles of the intestine were somewhat enlarged.

Kidney and Bladder: The kidneys were of enormous size and pale. On section, their normal markings were poorly defined. The mucosa of the bladder revealed numerous punctate hemorrhages.

Spinal Cord: The meninges contained punctate hemorrhages.

Bone Marrow: This was taken from the middle of the femur, and it was of a chocolate brown color.

Diagnosis.—1. Anatomic: (*a*) acute myeloid leukemia; (*b*) acute ulcerative endocarditis, and (*c*) infarcts of the spleen.

2. Microscopic: (*a*) chronic interstitial and parenchymatous nephritis; (*b*) bronchopneumonia, and (*c*) typical myelogenous leukemia.

COMMENT

There could be no doubt that the diagnosis of a leukemia was correct, and with the short duration and markedly increased white cell count of 716,000 in fifteen days, a leukemia of the most acute or malignant type. At first, with such a total blood count, enlarged mediastinal glands and disputed differential blood picture, one was inclined to make a diagnosis of the lymphatic variety. Later, with the marked increase in the total white cells and the appearance of many transitional types of myelocytes, one was disposed to favor myelogenous leukemia; but the diagnosis was established definitely only by the bone marrow findings.

WEBER'S SYNDROME

WITH REPORT OF A CASE *

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Weber's syndrome means, clinically, a complete or partial paralysis of the oculomotor nerve combined with a contralateral hemiplegia. Pathologically, it signifies some lesion of one of the cerebral peduncles (the crus cerebri). The practical value of this syndrome lies in the possibility of precisely locating a brain lesion, since the presence of Weber's syndrome is a sure evidence of involvement of a portion of the brain — the peduncular region — that so far has been absolutely inaccessible to operative interference.

Weber's syndrome will be complete and pronounced when that part of the peduncle is involved which is adjacent to the oculomotor nerve, that is, the inner portion. Otherwise, the oculomotor nerve may be spared, and then, in spite of the presence of a peduncular lesion, the syndrome will be lacking and will have no value as a sign of localization. Cases of this type have been reported by Andral, and by Pepper and Packard. As a rule, however, the peduncular lesion results in both oculomotor and pyramidal tract involvement. It was described long before Weber's day. Thus, Mohr minutely reports this syndrome twenty-three years before Weber, and Green mentions it eleven years before Weber. In 1859, that is to say, four years before Weber's paper was published, Gubler, in speaking of paralysis alternans, describes a case of Luton in which a hemiplegia of the left side was associated with a right third nerve paralysis, as the result of a softening of the right cerebral peduncle. Yet none of these authors give so precise and complete a description as Weber, who in 1863 pointed out the anatomic, clinical and pathologic characteristics of a peduncular lesion, which Charcot in 1891 proposed to call the Weber syndrome. Weber's contribution was followed by a number of reports, some of which were purely clinical. In other words, they had not been substantiated by necropsies, as in Jelliffe's three cases and Zosin's case. Some of these reports represented a somewhat modified clinical picture.

To the modified type of Weber's syndrome belongs the so-called Benedikt syndrome in which the paralyzed side shows a tremor resembling that of paralysis agitans, chorea or athetosis and in which the lesion was found to be not so extensive in the peduncles as in the so-called tegmentum, the region above the latter (Canfield and Putnam, Mendel, Block and Marinesco, Charcot and Gilles de la Tourette, d'Astros, and Gierlich and Hirsch).

The study of the few pathologic reports pertaining to Weber's syndrome shows that this can be caused by softening (Mayor, Oyon, d'Astros), hemorrhages (Weber, Rickards, Leteinturier, Leube), posthemorrhagic cysts (Andral), tumors, as tubercles (Mohr, Green, Bouveret and Chapotot, Greiwe), gliomas (Sutton, Rosenthal, Pepper and Packard), sarcomas (Beck), new growths not identified (Callender, Sharkey, Touche), hydatid cysts (Du Camp), abscesses (Stiebel), and a revolver bullet (Guillain and Hauzel). Tumors were by far the most frequent cause of the peduncular lesion, especially tubercules and gliomas. A gliomatous growth was also found in the following case:

REPORT OF CASE

History.—A girl, aged 9 years, entered the Cook County Hospital, Sept. 8, 1916, in the surgical service of Dr. Morf. July 3 of the same year, that is to say, about nine weeks previously, she had suddenly been seized with vomiting, dizziness and a headache. The headache was so severe and continuous that it had caused her to cry out with pain. Two weeks after the onset of the disease, the mother noticed a drooping of the left upper eyelid which was followed six weeks later by weakness of the right arm and leg. In this condition she entered the hospital, with a ptosis of the left eyelid of seven weeks' duration, and a hemiplegia of the right side of one weeks' duration. The child had dysentery at the age of 3 and earache at the age of 4, but the mother could not tell whether there was a discharge from the ear. At the age of 7 the patient developed a kyphosis, though the records do not show its exact location. The father and mother, who are 37 and 36 years old, respectively, as well as three sisters and one brother, are all living and well.

Examination.—The left upper lid drooped, covering the major portion of the palpebral fissure. The patient could not raise it more than a quarter of an inch. The left eyeball did not move up or down or inward. The left pupil was dilated, and did not react to light or in accommodation. The left eye was turned outward, the external movements being the only ones remaining. The right corner of the mouth was slightly drooping, and the right arm and leg were totally paralyzed, revealing exaggerated reflexes as well as a positive Babinski

* Owing to lack of space, a rather complete list of references to the literature has been omitted. This will appear in the author's reprints, a copy of which will be sent by him on request.

sign, a positive Chaddock and a positive Oppenheim, but a negative Gordon reflex. The left side did not show any abnormalities. Sensibility was present on both sides. The fundi showed a bilateral papilledema. The heart, lungs, genitourinary organs, mentality, speech, urine, spinal fluid, pulse, respiration and temperature were normal. A roentgenogram of the skull did not show the presence of a tumor.

Thus, the examination revealed an external strabismus of the left eye, a total oculomotor paralysis of the same side, a contralateral hemiplegia with exaggerated reflexes, and a bilateral papilledema. It was a typical Weber syndrome caused, we thought, by a tumor of the left cerebral peduncle. As brain tumors in children are usually tubercles, a diagnosis of tubercle of the left cerebral peduncle was made.

Operation and Necropsy.—Dr. Morf thought it advisable to reduce the intracranial pressure by an operation in the left temporal region, which was done, Sept. 30, 1916, and was followed by the death of the patient two weeks later. The postmortem examination revealed a glioma that had completely destroyed on the left side the gyrus hippocampus, the cornu ammonis, the cerebral peduncle, and the left oculomotor nerve. It spread upward, involving the region of the tegmentum and part of the optic thalamus, and invading the pons and the medulla. The tumor spared the optic chiasm, the anterior perforated space, and the hemispheres, but caused total obliteration of the third ventricle, greatly reduced in volume the aqueduct of Sylvius and the fourth ventricle, and produced an enormous dilatation of the anterior horns of the lateral ventricles. Those portions of the tumor that involved the cornu ammonis, the peduncle, the optic thalamus and the pons were exceedingly vascular and hemorrhagic, while the portions that invaded the posterior portion of the pons and the medulla were less vascular and showed an enormous number of large, well-developed glia cells. The walls of the vessels, especially in the peduncular region, appeared greatly thickened and hypertrophied, and contained few glia cells. Hemorrhagic foci were numerous, covering the entire field of vision in some specimens. Thus, the glioma was very extensive and evidently started in the hippocampal gyrus, which revealed evidences of deeper destruction than any of the regions previously mentioned, with the possible exception of the left oculomotor nerve and the left cerebral peduncle.

COMMENT

A case of this type affords excellent opportunities for studying the function of the hippocampal region, in order to discover its possible relation to the functions of taste and smell, an investigation which, unfortunately, was not made in this case. The extensive involvement of the neighboring regions, as the optic thalamus, the pons, etc., did not show any clinical symptoms that were exclusively those of a Weber syndrome. In a case of Boinet, a glioma of the optic striate region pressed on the chiasm, the optic tract, the left cerebral peduncle, and the upper third and lateral half of the pons. Clinically there was a Weber syndrome with a bilateral ophthalmoplegia and pseudobulbar paralysis. Somewhat similar cases were reported by Mingazzini. One patient showed a "perioptopeduncular" tumor of sarcomatous origin, which started from the hypophysis, secondarily involving the optic thalamus and the peduncles. The clinical picture revealed involvement of all the nerves of the base of the brain, a tendency to fall to the right, and twitchings in the left arm.

These cases demonstrate that a tumor of the peduncular region may give symptoms not exclusively confined to Weber's syndrome, if the neighboring areas are involved. Yet, in our case the clinical picture was that of a purely classical Weber syndrome in spite of the involvement of the tegmentum when, as I have previously mentioned, there should have been a Benedikt syndrome, that is to say, tremor of the paralyzed side combined with a contralateral oculomotor paralysis — symptoms which, in this case, were absent. They were also absent in the case of Greiwe, in which the tegmentum was totally destroyed by a tubercle. Another remarkable feature in our case was the patient's excellent mental condition, regardless of the fact that a large portion of the brain was totally destroyed. Absence of any mental symptoms was also observed by the majority of authors in cases of Weber's syndrome that were caused by softening or hemorrhages. In those patients in whom impairment of the intelligence was present, the symptoms could not possibly be ascribed, as d'Astros justly remarks, to the peduncular lesion itself; they should, he thinks, be ascribed rather to the accompanying cerebral arteritis or to syphilis.

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UTERINE RUPTURE FOLLOWING ANTERIOR HYSTEROTOMY

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Spontaneous intraperitoneal rupture of the uterus during labor is, very fortunately, of rare occurrence. Contrary to early teaching, it occurs most frequently in multiparas. An impaired integrity of the uterine wall from repeated pregnancies is more frequently a causative factor than obstructed labor. This may well be borne in mind as, I believe, the popular notion would lead us to suspect this calamity more particularly in the presence of obstruction.

The vulnerable scar, following a cesarean section, operates strongly as a predisposing cause of uterine rupture. Indeed, the likelihood of a tear through the old scar has found expression in the dictum, "Once a cesarean, always a cesarean."

Recently, a surgical procedure, known as anterior hysterotomy, has been brought forward as an easy, safe and sane method of inspecting the interior of the uterus. To me it seems only easy. The following case report is convincing argument in favor of "cleaning up" a miscarriage case in the old-fashioned way:

REPORT OF CASE

History.—Mrs. C., aged 23, married four years, referred by Dr. W. D. Moccabee of Cardington, had a good family history, and she had always been well until a miscarriage at three months occurred in December, 1915. At this time, that hemorrhage following fetal expulsion might be arrested, the abdomen was opened, the uterus incised, and the offending placenta removed (a cesarean operation after delivery!). Operative recovery was prompt. Eighteen months later, the patient came to labor at full term. Pelvimetry bespoke ample pelvic measurements. The wise suggestion of her physician, that she enter a hospital for confinement, was rejected. Mild labor pains appeared irregularly for about forty-eight hours, after which they did not return. I saw the patient in consultation, Jan. 28, 1917. There had been no labor pains for several hours. Dr. Moccabee stated that he suspected uterine rupture through the old scar, although the symptoms were quite atypical. The pulse was rapid, but of good volume. Gastric dilatation was in evidence. There were no fetal heart sounds. Profound shock was absent, and the patient said she felt quite well. The uterus and fetus could not be separately palpated through the abdominal wall. The patient stated that she heard something crack and felt something give way about the time her pains stopped.

She was removed to Grant Hospital, where an anesthetic (ether) was administered, and, after the uterus had been explored to verify our diagnosis, abdominal section was made. The dead baby was removed from the peritoneal cavity, hysterectomy was rapidly performed, and a quart of physiologic sodium chlorid solution administered intravenously. An uninterrupted recovery supervened.

Specimen.—Examination of the uterus revealed that it had yielded at the old hysterotomy scar. This was not remarkable for however carefully the incised uterine wall may have been repaired, Nature frowned on the job. Muscular union was all but nil, the infolding endometrium approximating the peritoneum—an ugly rent, indeed.

SUMMARY

1. Anterior hysterotomy, in a child-bearing woman, is not an innocent procedure.

2. When uterine rupture occurs through scar tissue, prognosis is more favorable because there is less likelihood of severe hemorrhage.

3. The vulnerability of a cesarean scar makes it desirable for such patients to enter a well-equipped hospital for all future deliveries.

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FROSTBITE AS A PREDISPOSING FACTOR IN CARCINOMA OF THE EAR

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Pusey has called attention to the important part played by long standing, dry seborrhea in the production of senile keratoses and similar precancerous lesions of the skin, and Heidingsfeld has shown that cicatricial tissue frequently serves as a starting point for cutaneous carcinoma.

The fact that areas of skin that have been subjected to frostbite, and especially to repeated frostbite, are abnormally susceptible to cancerous involvement has not, however, been sufficiently emphasized. The parts commonly involved are the ears, particularly the helixes, and the cheeks. The great frequency with which these areas are attacked can be appreciated only by a study of a considerable number of case histories. Of forty-six cases of seborrheic keratosis involving the ears and cheeks, examined during the twelve months elapsing Nov. 1, 1917, twenty-seven gave a history of frostbite. Of the twenty-seven, twenty-one presented one or more malignant growths on the affected areas. The majority of the seborrheic keratoses were of the keratoid type. Almost 90 per cent. of the carcinomas were of the basal cell variety. In three instances both the basal and squamous cell varieties were represented.

Judging from the result of my own observations, it appears that repeated exposure to very low temperatures tends also to reduce local resistance to the progress of the malignant growth, and thus becomes a factor in prognosis as well as in etiology.

The most important prophylactic measure is, of course, adequate protection of the parts commonly attacked. Should keratoses develop, the frequent application of an ointment containing small amounts (from 1 to 5 per cent.) of salicylic acid may be tried. In some instances, double this proportion of sulphur may also be advantageously added. In more advanced cases, suspiciously or frankly malignant, radium usually serves admirably, and possesses the great advantage of leaving the skin in a practically normal condition.

In attacking squamous cell growths of the ear, and especially if the associated lymph nodes are involved, radical excision is, in my experience, the method of choice.

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A STATISTICAL STUDY OF LEPROSY IN THE PHILIPPINE ISLANDS

FROM THE HISTORIES OF TEN THOUSAND CASES ISOLATED IN THE CULION LEPER COLONY

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On the theory that facts of interest and of possible bearing on the transmission of leprosy might be obtained from a study of the personal histories of a large number of lepers, an investigation has been made of the "individual records" of each leper on his admission to the Culion Leper Colony.

The histories, which, of necessity, are very brief, contain, in addition to the name of the individual, the age, sex, nationality, race, birthplace, last place of residence, date of admission to the colony, marital relation, family contact history, probable duration of the disease, and a brief description of the physical condition of the patient at the time of admission.

TABLE 1.—AGE AT WHICH INFECTION IS ASSUMED TO HAVE TAKEN PLACE

Culion			Hawaii			
Ages	Number	Per Cent.	Ages	Number	Total	Per Cent.
1- 5	70	0.72	1- 5	8	8	0.75
			6-10	36		
6-15	2,335	24.30	11-15	163	219	20.69
			16-20	204		
			21-25	143		
			26-30	114		
16-35	4,888	50.87	31-35	79	540	51.04
			36-40	89		
			41-45	44		
			46-50	48		
			51-55	41		
			56-60	26		
			61-65	18		
			66-70	18		
			71-75	3		
			76-80	3		
36 upwards	2,316	24.10	81-85	1	291	27.50
Totals....	9,609	99.99			1,058	99.98
Not estimated...	816				2	
	10,425				1,060	

Since a large number of the lepers of the Philippine Islands have only a slight knowledge of the simplest principles of hygiene and sanitation, questions regarding their views of the possible source of their infection bring little, if any, information worthy of serious consideration.

Since we lack exact knowledge of the method of transmission of the disease, exact knowledge of the time at which infection takes place would be of great value in the study of individual cases. Table 1, showing the ages at which infection is assumed to have taken place, is only relatively correct, since the period of incubation of leprosy is unknown and therefore has not been considered. The figures are based on the time at which the first symptom of the disease was recognized.

The remarkable similarity between these figures and those obtained by McCoy[1] in the Hawaiian Islands war-

1. McCoy: A Statistical Study of Leprosy in Hawaii, Pub. Health Bull. 66, 1914.

rants their comparison at this point. The ages obtained from the Hawaiian statistics, it should be noted, are reckoned from the time of apprehension and not from the approximate date of infection.

Twenty-nine per cent. of the lepers segregated in Culion have given a definite history of previous contact with at least one leper relative. This percentage excludes a large margin of error, since it is a frequent occurrence for a leper on admission to give a negative family contact history. Then months or years later, a brother, sister, cousin or some other relative may be admitted as a leper in whom the existence of the disease was not suspected when the first relative was isolated.

In a study of the lepers giving a history of contact with only one leper relative, there were found certain significant facts about the distribution of the infection among the members of the families. They appear in Table 2.

TABLE 2.—DISTRIBUTION OF LEPROSY AMONG MEMBERS OF FAMILIES

Relative Who Had Leprosy	Lepers	
	No.	Per Cent.
Mother	106	4.77
Father	145	6.53
Son	113	5.09
Daughter	58	2.61
Brother	546	24.57
Sister	245	11.02
Nephew	85	3.82
Niece	44	1.98
Aunt	79	3.55
Uncle	130	5.85
Wife	17	0.75
Husband*	23	1.03
Grandfather	5	0.22
Grandmother	6	0.27
Grandson	12	0.54
Granddaughter	5	0.22
Son-in-law	1	0.04
Cousin	602	27.05
Total	2,222	99.92

* As has already been explained, there is a definite and unavoidable error in these figures. Since they are based on the records of lepers isolated in Culion only, no allowance has been made for the leper relatives remaining alive or dead in the provinces. For example, seventeen wives and twenty-three husbands were lepers, the unaccounted-for wives dying before their husbands were isolated in Culion.

If these cases are viewed from another standpoint to show a possible relationship between sexes, the data given in Tables 3 and 4 are obtained.

TABLE 3.—CONTACT BETWEEN LIKE SEXES

Persons Infected	No.	Per Cent.
Mother and daughter	81	4.48
Father and son	165	9.12
Brother and brother	398	22.00
Sister and sister	124	6.85
Uncle and nephew	144	7.96
Aunt and niece	60	3.32
Grandfather and grandson	9	0.49
Grandmother and granddaughter	6	0.33
Cousins, like sexes	117	6.47
Total, like sexes	1,104	61.02

TABLE 4.—CONTACT BETWEEN UNLIKE SEXES

Persons Infected	No.	Per Cent.
Mother and son	106	5.85
Father and daughter	70	3.87
Brother and sister	269	14.87
Uncle and niece	60	3.32
Aunt and nephew	74	4.09
Grandfather and granddaughter	3	0.17
Grandmother and grandson	10	0.55
Cousins, unlike sexes	72	3.97
Husband and wife	40	2.21
Son-in-law (and mother-in-law)	1	0.05
Total, unlike sexes	705	38.95
Cousins, sex contrast not known	413	
Final total	2,222	

If we assume, in these instances, that the disease has been transferred from leper to relative, nearly two thirds of the cases, exclusive of the cousins whose records failed to show the sex of the other infected cousin, are between relatives of like sexes. Notable is the record of contact among brothers and among sisters, which shows 522 cases of the disease transferred presumably from brother to brother and from sister to sister, in contrast to 269 cases of assumed transmission from brother to sister, or vice versa.

Rearranging these tables in order that a comparison may be made with somewhat similar statistics from Hawaii, and abridging the Hawaiian table to show family contacts only, we obtain the data given in Table 5.

TABLE 5.—COMPARISON OF LEPROSY AMONG RELATIVES IN CULION AND HAWAII*

	Culion		Hawaii	
	No.	Per Cent.	No.	Per Cent.
Fathers or mothers	251	11.30	117	37.02
Grandparents	11	0.49	6	1.89
Grandchildren	17	0.77	1	0.31
Sisters or brothers	791	35.61	102	32.27
Sons or daughters	171	7.69	12	3.79
Uncles or aunts	209	9.41	24	7.59
Cousins	602	27.10	18	5.69
Nephews or nieces	129	5.80	8	2.53
Husbands or wives	40	1.80	28	8.85
Totals	2,221	99.97	316	99.94

* The percentages are not from the original but are here calculated for convenience. The figures are subject to the error explained in the footnote to Table 2.

In addition to the lepers giving histories of contact with one leper relative, there were 182 families in which occurred infection of three or more members, distributed as shown in Table 6.

TABLE 6.—DISTRIBUTION OF FAMILIES IN WHICH LEPROSY OCCURRED IN THREE OR MORE MEMBERS

Members of One Family Infected	No. of Instances
8	1
7	2
6	5
5	9
4	35
3	130

The distribution of infection among the members of the individual families is shown in Table 7, from which it will be seen that the most frequent cases of infection among relatives were among three cousins, this combination being recorded twenty-seven times. More than half of the individuals infected were brothers and sisters, of whom 130 gave histories of contact with ninety-seven leper parents or grandparents, while 196 brothers and sisters gave no history of contact with leper parents or grandparents. Eighty-five cousins gave histories of contact with leper cousins only.

Of the 10,425 lepers admitted to Culion, 3,674, or 34 per cent., were married before admission. Of the latter number only forty, or 1 per cent., represent instances in which both husband and wife were known to be lepers.

The distribution of the disease among the tribes is given in Table 8.

In the Philippine Islands, as elsewhere, leprosy more frequently affects the male than the female. Of those segregated in Culion, 66.7 per cent. have been of the male sex.

The admission records show that the attempt to separate the cases into types of disease has proved unsatisfactory, as some of the cases have been classified as "anesthetic" or "tubercular" from the most pronounced symptom only, while the description of the cases show them to be, in some cases, "mixed." The larger majority of the cases, however, have been "tubercular" or "nodular," with the "mixed" cases coming second in point of numbers.

According to computations from records of 5,000 consecutive deaths, the average duration of leprosy, that is to say, the period existing between the time of recognition of the first symptom of the disease, and death, is 7.332 years. The longest duration of the disease of which authentic record was found is forty-eight years, the patient being a woman of 63 now living, who has spent eight years in Culion.

TABLE 7.—INFECTION AMONG MEMBERS OF INDIVIDUAL FAMILIES

No. of Families Thus Infected	Members Infected											Total Relatives Infected in One Family
	Grandfather	Grandmother	Father	Mother	Uncle	Aunt	Brother	Sister	Nephew	Niece	Cousin	
1	....	1	....	1	....	...	3	1	...	...	2	8
1	....	....	....	....	....	...	4	3	...	...	...	7
1	....	....	1	....	1	...	2	2	...	...	...	6
1	....	....	1	....	....	...	3	1	...	...	...	6
1	....	....	....	1	....	...	1	3	...	...	1	6
1	1	....	1	1	1	...	1	1	...	...	...	6
1	....	....	....	....	....	...	3	1	...	...	1	6
1	....	....	1	....	1	...	2	1	...	...	1	6
3	....	....	....	....	....	...	2	3	...	...	...	5
2	....	....	....	....	....	...	2	1	...	...	2	5
1	....	....	....	....	1	...	3	1	...	...	...	5
1	1	....	1	1	....	...	1	1	...	...	...	5
1	....	....	....	1	....	...	1	1	2	...	...	5
1	....	....	1	....	....	...	2	2	...	...	...	5
6	....	....	....	....	....	...	2	2	...	...	...	4
3	....	....	....	....	1	...	1	2	...	...	...	4
2	....	....	1	....	....	...	3	1	...	...	1	4
2	1	....	1	....	1	...	1	....	...	...	...	4
2	....	....	1	1	....	...	2	1	...	...	...	4
1	....	....	....	....	1	...	1	1	...	...	1	4
1	....	....	1	....	....	...	3	....	...	...	...	4
1	....	....	....	1	....	...	1	1	...	...	1	4
1	....	....	....	1	....	...	3	....	...	...	...	4
1	....	....	1	....	....	...	1	2	...	...	2	4
1	1	....	1	....	1	...	....	1	...	...	...	4
1	....	....	....	....	1	...	3	....	...	...	1	4
1	....	....	....	1	....	...	....	1	...	...	1	4
1	....	....	....	....	....	...	3	....	...	...	1	4
27	....	....	....	....	....	...	3	....	...	...	....	3
11	....	....	1	....	....	...	2	....	...	...	....	3
9	....	....	....	....	....	...	3	....	...	...	....	3
8	....	....	....	....	1	...	1	1	...	...	....	3
6	....	....	....	....	....	...	1	2	...	...	....	3
5	....	....	....	....	....	...	2	....	...	...	1	3
4	....	....	4	....	....	...	1	1	...	...	....	3
4	....	....	....	....	....	...	2	1	...	...	....	3
4	....	....	....	1	....	...	1	1	...	...	....	3
3	....	....	1	....	....	...	1	....	...	...	1	3
3	....	....	....	....	1	...	....	....	1	...	1	3
3	....	....	....	1	1	...	1	....	...	...	....	3
3	....	....	....	1	....	...	....	1	...	...	1	3
3	....	....	....	1	....	...	1	....	...	...	1	3
2	....	....	1	....	1	...	1	....	...	...	....	3
2	....	....	....	....	1	...	2	....	...	...	....	3
2	....	....	....	....	....	1	1	1	...	...	....	3
2	....	....	....	....	....	...	....	2	...	...	1	3
2	....	....	....	....	....	...	1	1	...	...	1	3
2	....	....	1	....	....	1	....	1	...	...	....	3
2	....	....	1	....	....	...	1	....	...	...	1	3
2	....	....	1	....	....	...	....	1	...	...	....	3
2	....	....	1	1	....	...	1	....	...	...	....	3
2	....	....	....	1	....	...	1	....	...	...	....	3
2	....	1	1	....	....	...	1	....	...	...	....	3
1	....	....	1	1	....	...	....	....	...	...	1	3
1	....	....	....	....	....	1	....	....	...	...	1	3
1	....	....	....	....	....	...	....	3	...	...	....	3
1	1	....	....	....	....	...	1	1	...	...	....	3
1	....	....	....	1	....	...	....	2	...	...	....	3
1	....	....	1	....	....	...	....	2	...	...	1	3
1	....	....	....	....	1	...	....	2	...	...	....	3
1	....	....	1	1	....	...	....	....	...	1	....	3
1	....	....	....	....	....	1	....	....	...	1	....	3
1	....	....	....	....	....	...	....	2	...	...	1	3
7	2	56	35	37	10	207	125	7	4	137		

Total Members Infected, 627

In the ten years since the beginning of segregation of lepers in the Philippine Islands, 357 babies in Culion have been born of leper parents. Of these, 166, or 46.5 per cent., have died, twenty-four, or 6.7 per cent., being stillborn, fifty-nine, or 16.5 per cent., dying before reaching the age of 1 month, forty, or 11.2 per cent., dying before reaching the age of 3 months, and the remainder of the 166 living less than three years.

Thirty-seven of the 357 babies were released from Culion at early ages, after they had been examined clinically and bacterioscopically and had been reported not to be lepers. One of these was returned to the colony at the age of 4 years as a leper. Of the remaining thirty-six, little is known save that several died during an epidemic of bacillary dysentery in the institution in which they were temporarily placed.

Each of the 154 children remaining in Culion has been examined repeatedly both clinically and bacterioscopically. Sixteen, or 10.4 per cent., are lepers.

On several occasions, when lepers in the provinces were collected for segregation, leper mothers were found who could make no arrangements for the care of their babies, in which cases the infants were brought to Culion. Of nine of these children isolated with their mothers, three have died, one has been returned to the provinces, and five remain in Culion. Four out of these five are lepers, having been exposed to infection for from seven to ten years.

TABLE 8.—DISTRIBUTION OF LEPROSY AMONG TRIBES

Tribes	No.	Approximate Percentage of the Tribe Population
Visayans	5,338	0.17
Tagalogs	1,997	0.14
Ilocanos	1,542	0.19
Bicolanos	1,184	0.21
Pampangos	171	0.06
Pangasinans	100	0.01
Members of small tribes and foreigners	88	
	10,425	

COMMENT

Granting that the *Bacillus leprae* Hansen, or the *Mycobacterium leprae*, is the causative agent of leprosy, and that no organism can arise de novo, the conclusion is drawn that the disease leprosy arises in an individual as the result of heredity or contagion. The word "contagion" is here used in its broad sense as the transmission of a disease from one person to another by direct or indirect contact.

It is acknowledged, in a scientific sense, that no parasitic disease can be inherited, although infection of the ovum or spermatozoon is possible, as well as a hereditary predisposition to leprosy. The fact, however, that 71 per cent. of the lepers segregated in the Culion Leper Colony came from families in which there was only one case of leprosy recognized, and that only a small proportion of the remaining 29 per cent. represent contact between parent and child, would tend to confirm the already firm belief that heredity plays an unimportant rôle in the transmission of leprosy.

It is to be regretted that, in the study of the histories of the 10,425 patients admitted to the Culion Leper Colony, no facts were found which furnished conclusive evidence on the transmission of the disease. It is interesting, however, to consider inversely the relation of certain of the facts obtained and the now considered theories of the transmission of leprosy.

Hansen is said to have remarked, "There is hardly anything on earth, or between it and heaven, which has not been regarded as the cause of leprosy." While the

mystery of the etiology of the disease has been solved by Hansen, practically every thing and condition has since been considered in an effort to demonstrate the transmitting agent.

Climatology.—Nothing obtained from this study has demonstrated that the local climatic conditions either predispose to the disease or directly affect the transmission.

Local Geographic Distribution.—While the great majority of the lepers have come from the seacoast, it must be understood that the population of the Philippine Islands is, to a large extent, distributed along the seacoast. The mountain tribes, in spite of their relative inaccessibility, are not free from the disease, several of them being represented in the colony.

Air and Dust.—While the histories taken do not consider the possibility of transmission by air and dust, it is not without significance that in the ten years since the opening of the Culion Leper Colony, only two employees of the colony have developed the disease. One of these is a Caucasian ecclesiastic who was pronounced a leper after five years of exposure, and the other, a Filipino laborer who was pronounced a leper at the end of a year's employment in the colony. The latter patient comes from an infected family, having a cousin who was a leper for several years previous to the laborer's isolation. The average number of nonleprous employees in the colony is 200, nearly thirty of whom have been on the reservation for ten years.

Food.—Rice and fish comprise a large proportion of the Filipino diet. As each member of the family partakes of a fare almost exactly similar to that of the other members, it is difficult to conceive of how one might be infected to the exclusion of other members of a frequently large family. It is therefore negatively concluded that neither the native diet, nor any particular article of food has any relation to the transmission of leprosy, aside from the general predisposition to disease which may accompany the ill-nourished condition of the bodies of many Filipinos.

Sexual Transmission.—The fact that but 1 per cent. of the consorts of married lepers have developed the disease would tend to show that the sexual act, as such, has little, if any, bearing on the tranmission of leprosy.

By consideration, largely with negative statements, there have been eliminated from this discussion some of the more generally considered possible means of transmission of leprosy. There remain for consideration transmission through physical contact and through secondary parasites.

Physical Contact.—The large proportion of the cases of infection which have presumably been transmitted among brothers and sisters, or among cousins, would suggest physical contact as an important factor in the transmission of the disease. On the contrary, the relatively small percentage of transmission between parent and child, or the smaller percentage between husband and wife would suggest that even prolonged and intimate contact alone is not sufficient.

Secondary Parasites.—The bacillus of leprosy has, of itself, no known powers of penetration. It is therefore reasonable to believe that should it be transferred from person to person by a secondary parasite, this parasite must habitually implant the bacillus in a suitable place. One is then forced to exclude all parasites having no powers to penetrate the human skin, which is the part most likely to be habitually attacked.

The mosquito is physically capable of transplanting the bacillus of leprosy beneath the human skin. There is, however, nothing in the life history of the mosquito to lead one to suspect that it would bite and infect with leprosy one member of the family, to the frequent exclusion of all others, or to select and infect brothers and sisters to the exclusion of other relatives. Nor does anything in the life history of the mosquito explain the presumed transmission of the infection between like sexes. By similar reasoning, flies, ticks, lice and bedbugs may be excluded as probable agents of transmission, provided each member of a household is similarly exposed to infestation.

The theoretically ideal transmitting agent, then, must have the ability to penetrate the human skin, to select by preference certain members of the family, brothers, sisters or cousins, and to transplant the bacillus preferably from one sex to a like sex. It also includes the element of physical contact.

CONCLUSIONS

1. One half of the cases of leprosy segregated in Culion have been diagnosed in adolescence.

2. Twenty-nine per cent. of the lepers gave definite histories of contact with leper relatives. No record has been made of contact with lepers other than relatives. It is probable that carefully taken histories would have revealed contact histories for all the lepers isolated, since the disease is widespread throughout the islands.

3. Thirty-five per cent. of those giving histories of contact with a single leper relative were sisters and brothers, 27 per cent. were cousins, while 11 per cent. were leper children and 7 per cent. leper parents.

4. In the occurrence of infection of two or more relatives, the majority of cases were among members of like sexes, the noteworthy exception being the number of mothers and sons infected in excess of the number of mothers and daughters.

5. Numerous records show multiple infection within families, spreading over one, two or three generations, more than half of the infected persons being brothers and sisters.

6. In 1 per cent. of the lepers who were married before admission to Culion, the infection was between husband and wife.

7. The male sex is more frequently infected.

8. The average duration of leprosy is 7.3 years.

9. Mortality among children born of leper parents is high. The incidence of infection among children living in the colony for from one to ten years is 10.4 per cent.

10. Infection of children born of parents, one of whom is a leper, and living among lepers for from seven to ten years, is 44 per cent.

11. From this study, nothing of importance, other than circumstantial evidence, has been learned regarding the transmission of leprosy.

Additions to Registration Area.—Maryland, Virginia and Kentucky have recently been added to the list of states in the Registration Area for births of the United States. Conscription and enlistment in the Army have shown the need for accurate birth statistics and have stimulated interest in this important matter. Tests by agents of the U. S. Census Bureau of the completeness of birth registration in Virginia and Kentucky gave a rating of over 90 per cent., which is the figure required for registration. Similar tests are being made in Indiana and New Jersey, with North Carolina, Ohio and Utah to follow, and within the next two years it is expected that the Registration Area will comprise at least two thirds of the population of the United States.

LEIOMYOMA OF THE APPENDIX

REPORT OF TWO CASES

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Both of these tumors were discovered in the course of a routine pathologic examination of the surgical specimens. In neither case was there any clinical evidence indicating or suggesting their presence.

REPORT OF CASES

CASE 1 (C-1184).—*Clinical Data.*—Mrs. S. B., aged 40, was admitted with symptoms of general pelvic inflammation. Operation was performed the day following admittance, consisting of removal of the uterus, both tubes, one ovary, and the appendix. Recovery was uneventful.

Surgical Findings.—The uterus was distorted by the presence of many fibroids of all varieties, extending from the fundus to the cervix. The lumen was partially occluded by submucous fibroids and blood clot. Both tubes were swollen, the distal ends closed. The ovaries were cystic. The appendix was small. The distal end was kinked, the color, normal. The lumen was obliterated.

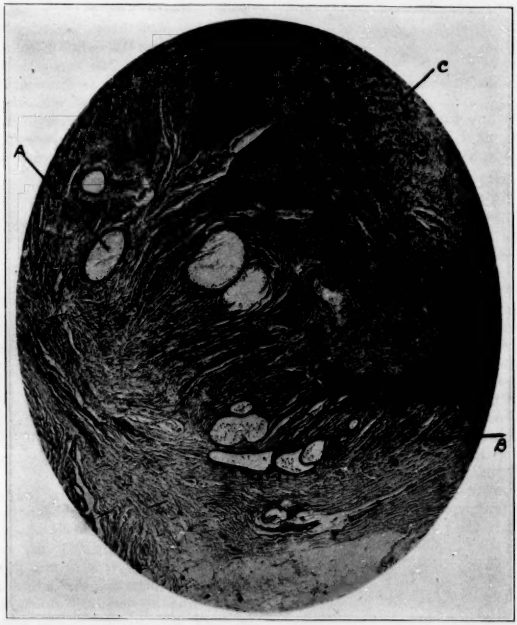
Pathologic Findings.—There were multiple fibromas of the uterus. No endometrium was seen. The tubes showed moderate chronic inflammatory reaction. Many small round cells were noted. The ovary was very fibrous, with numerous cysts. The lumen of the appendix had been entirely obliterated. The muscular coats showed some fibrosis, moderate in amount. There had been marked proliferation of the muscle tissue. This growth had progressed to the extent of obliterating the lumen. The mucosa had apparently suffered pressure atrophy to the extent shown in the illustration, except in isolated areas where it still persisted as the lining wall of small cysts.

CASE 2 (SA-2610).—*Clinical Data.*—Mrs. A. G., aged 36, was admitted complaining of pain in the right lower quadrant, of five months' duration. The onset was not acute. Recently, there had been pain in the left lower quadrant; menstruation was irregular; leukorrhea was present; there had been no pregnancies. Operation was followed by uneventful recovery.

Surgical Findings.—The uterus was normal in size and consistency, but was held downward, backward, and to the left by firm adhesions. The left tube was partially adherent to the back of the uterus, and was not enlarged or diseased. The right tube and both ovaries apparently were normal. The appendix was found to be surrounded by many firm adhesions. It was enlarged, angulated 3 cm. from the tip, and the distal portion for about 1 cm. was constricted, firm, and paler than normal. On the opening of the peritoneal cavity through a median incision, the entire abdominal contents were found to be covered by a transparent, membranous veil, making it appear as though all the viscera were retroperitoneal.

Pathologic Findings.—Only the appendix was removed. This measured 3.5 cm. in length, by 0.75 cm. in diameter. The serous surface was grayish pink. The proximal end showed a patent lumen, partially necrotic, and sloughed mucosa, the submucosa heavily fibrosed, and showed many small round cells throughout, some thickening of the muscularis, and slight fibrosis of the serosa.

At the distal end there were observable some remains of the original muscularis as such, but this had hypertrophied so that the mass of muscle tissue completely filled and obliterated the lumen. Van Gieson's stain revealed some fibrous growth, but the large bulk of the obliterating mass was smooth muscle tissue. The mucosa was not observed, and had probably undergone complete atrophy. The serosa was normal.



Leiomyoma of appendix: *A*, remains of mucosa; *B*, muscle wall; *C*, tumor mass. Notice the arrangement of nuclei of the tumor, like columns of troops.

SUMMARY

Both patients were women, aged 36 and 40, respectively. The presence of uterine fibromas was noted in one, but not ascertained in the other. Both appendixes were removed, one as a routine surgical procedure, the other on clinical evidence of chronic inflammation. Microscopically both appendixes showed evidence of chronic inflammation of long standing, and in both the seat of the tumor mass was in the extreme distal end. The pseudo-adenomatous condition of the one is interpreted as an intermediate stage in a process affecting the mucosa, and one which has gone on to complete obliteration in the other.

Ancient Prescribing.—Ancient Greek prescriptions were of a curious character, according to our present ideas. For instance, they directed that no medicine should be administered to a sick cow by a woman; they lauded cabbage as a cure for almost every ill; placed great stress on the number 3 and supposed medicines to be more active when 3 drams, 3 ounces or 3 times any quantity was given, and they at the same time directed the repetition of cabalistic words and incantations.—Wall, *The Prescription.*

BRACHIAL NEURITIS AND SCIATICA

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A misapprehension as to the frequency of brachial neuritis and of sciatic neuritis or sciatica I believe

Fig. 1 (Case 1).—Arthritic side, showing free flexion of thigh.

to be quite general. At any rate, I do know that in the profession at large, as I meet it, the diagnosis of these diseases is made altogether too frequently.

BRACHIAL NEURITIS AND SHOULDER ARTHRITIS

A careful review of my records (private practice) for the last ten years shows that, of the patients referred to me supposedly with brachial neuritis, only about one in ten really had it. Approximately four fifths were cases of arthritis of the shoulder joint. The other one tenth was made up of cases of bursitis, syphilis, neoplasm, cervical rib, postherpetic pain, osteomyelitis, cervical caries and cervical arthritis. Indeed, when a patient states that he has for some time been troubled with neuritis of the shoulder or arm, one is pretty safe in assuming that it is something else, probably arthritis.

Why should so many physicians have made an erroneous diagnosis of brachial neuritis? Principally, I think, on account of the relative prominence of pain,

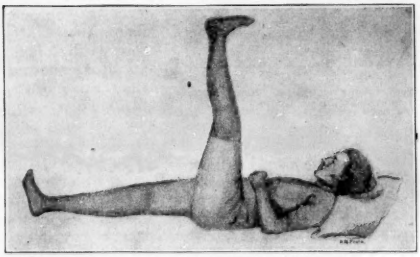

Fig. 2 (Case 1).—Arthritic side; no Lasègue sign.

because this pain was not distinctly localized in the shoulder joint and probably because they did not sufficiently examine the patient. A careful examination seldom leaves one in doubt.

Neuritis is rare; the pain is constant, is influenced not at all or but little by passive movement of the shoulder, and is generally influenced not greatly by active movement, though the patient moves the arm carefully. Ordinarily, the suffering is intense, such as never occurs in arthritis except in the worst cases, when the patient cannot move the joint at all. Intermittent, grumbling pain is very, very rarely that of neuritis. There is distinct, generally exquisite, tenderness of the cords of the brachial plexus or of the nerve trunks or of both. In some cases there is distinct though slight tactile anesthesia and sometimes surface hyperesthesia—more properly speaking hyperalgesia. Tingling or subjective numbness of fingers or forearm is frequent. The deep reflexes of the arm are diminished or lost. The disease is nearly always self limited. It lasts a few weeks or a few months (in bad cases from six to nine months), there is definite recovery, and it seldoms recurs.

Arthritis of the shoulder, on the other hand, is very common, and the pain fluctuates more or less, even when very bad. In the less severe cases it is intermittent. Not only is it intermittent within the twenty-four hours, but the patient has his good and his bad days. Often the pain seems to be influenced by the weather, and for some reason it is apt to be more annoying at night. As before stated, often the pain is

Fig. 3 (Case 1).—Normal side; leg almost horizontal; that is, no fabere sign.

not distinctly localized in the shoulder joint. In a great many cases it is felt chiefly *at about the insertion of the deltoid*. For this I have no adequate explanation, but I know that it is very misleading. More than once I have known it to lead to a diagnosis of osteomyelitis. Sometimes the pain is rather diffuse, radiating up into the neck and down the arm. This pain in the neck and down the arm I am quite sure is often due to concomitant arthritis of the cervical spine, the nerve roots being irritated where they pass out through the intervertebral foramina. In some cases of shoulder arthritis alone I have no doubt that the nerve trunks may be involved where they pass close to the joint.

The striking feature, however, of the arthritis cases is that in whatever part the pain may be felt, there are certain movements of the shoulder joint, active or passive, which cause pain. These are by no means always the same; but by all odds the most frequent is adduction of the humerus with retraction and internal rotation, the movement involved in crossing the forearms behind the back. Consequently the woman has difficulty in fastening her skirts and her waist behind, and the man in putting his hand into his hip pocket. Another good test movement is to extend the arm straight upward and then rotate it as if operating a screw driver. In the examination of such a case,

movements in different directions, with the arms in different positions, should be carried out against resistance. For instance, with the arms extended horizontally and parallel in front of the upright trunk, the hands are pushed toward each other, away from each other, upward and downward *against resistance*. With the arms extended sidewise, making a cross with the body, resistance movements are made upward, downward, forward and back, etc. One or more of these movements will be pretty sure to be painful, which would not be the case in mild neuritis. But it must be emphasized that in many cases of subacute and chronic arthritis, many movements or most movements are entirely painless. I have had a number of patients who could play golf with perfect freedom; and such exercises as hammering, sawing, rowing and sweeping may have no immediate influence on the pain. Likewise, in the chronic or subacute cases, local tenderness may be but slight or even absent. Of course in acute arthritis practically all movements of the joint are painful, and there is limitation of passive motion, neither of which conditions obtains in neuritis.

Of very considerable assistance in the diagnosis is the state of the deep reflexes. These are uniformly

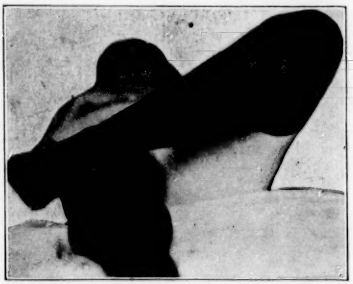

Fig. 4 (Case 1).—Arthritic side; knee cannot be normally depressed: fabere sign.

brisk, and sometimes considerably exaggerated. Even when the muscles are quite atrophic and the appearance of the arm would indicate loss of the deep reflexes, the wrist jerk and triceps jerk will be found to be quite lively, more so than those of the well side. The same, as a rule, applies to the scapular jerks.

Wasting of shoulder and arm muscles sometimes leads the observer astray. There seems to be a common feeling that atrophy means nerve trouble. Consequently wasted deltoid, biceps and triceps apparently lend color to the view that the shoulder pain is neuritic. Just how arthritis causes atrophy of muscles moving the affected joint is still matter for speculation; but the fact of its general presence is of daily observation. The atrophy may be very marked and the arthritis relatively mild. I once saw a boy with mild multiple arthritis in whom the muscular wasting was so obtrusive that the case was thought to be one of advanced progressive muscular atrophy. Indeed, I have known men high in the profession to be misled by this arthritic atrophy.

There are two more signs of value: signs, I regret to say, that seem to be infrequently looked for. These are fever and leukocytosis. In very mild and chronic cases they may not be found, but such are exceptional. Repeated examinations, especially when the pain is at its worst, will nearly always show at one time or another (sometimes uniformly) a slight rise of temperature (from 99 to 100 F.) and a slight increase in

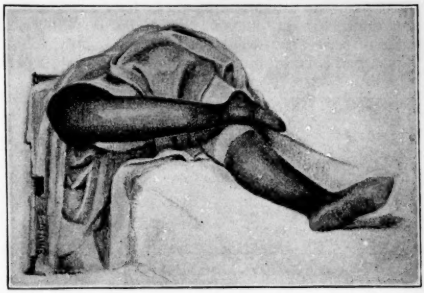

Fig. 5 (Case 1).—Same as Figure 3.

the leukocyte count (from 8,000 to 9,000 or 10,000, occasionally 12,000). These two signs naturally lead us toward the conclusion that the arthritis is of infectious origin, and this conclusion is supported by the fact that less obtrusive arthritis elsewhere can often be found. Even when the patient avers that he has no other trouble, painstaking inquiry and examination frequently will show that his statement is inaccurate. Other joints oftenest involved are the opposite shoulder and the articulations of the cervical spine. Perhaps next in order come the lumbar and the dorsal spine, the hip and the finger joints. Furthermore, it is not so very unusual to find a coexistent indurative headache or soreness and tenderness of the occipital or suboccipital region, troubles I believe to be almost invariably due to infection, the focus generally being somewhere in the head or the throat. Of like significance is tenderness of the trapezius or other neck muscles — a fairly frequent concomitant.

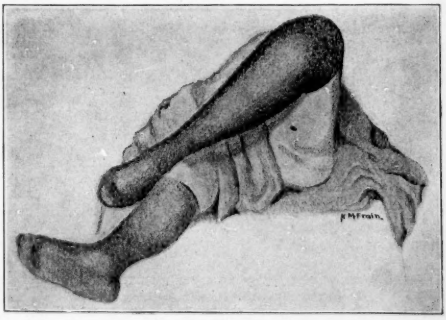

Fig. 6 (Case 1).—Same as Figure 4.

SCIATICA AND ARTHRITIS OF THE HIP

Thirty-odd years ago Dr. L. Putzel of New York called to my attention the frequent mistaking of chronic arthritis of the hip for sciatica. Since that time I have been interested in observing how much

more common is the arthritis than sciatica, and how frequently an erroneous diagnosis is made.[1] Outside of large charity hospitals I believe sciatica to be a relatively rare disease, while arthritis of the hip is one of the most common. This is no new assertion. Many years ago that wonderful observer Jonathan Hutchinson expressed the opinion that a certain number of cases of sciatic pain were due to "trouble in the joint." Since then similar statements have now and then been

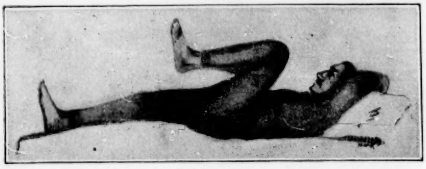

Fig. 7 (Case 2).—Arthritic side; good flexion.

made, and recently the elder Bruce[2] has published a remarkable little book sustaining the thesis that the pathology of sciatica is "trouble in the hip joint." Inferentially he concludes that all sciatica is hip joint trouble. I cannot go so far as he because I am quite sure that occasionally one does see a true neuritis of the sciatic nerve or sacral plexus, and semioccasionally an example of neuralgic sciatica — or at least of sciatica in which the signs of neuritis, except pain, are absent.

Without touching on the reasons why arthritis leads to a diagnosis of sciatica, I shall simply mention a few signs and symptoms indicating the former and excluding the latter.

Sciatica, like brachial neuritis, causes no limitation of passive motion, with one notable exception — the Lasègue[3] sign — whereas, arthritis of the hip is pretty sure to interfere with some movement or other. Especially is there one sign, so far as I know never present in sciatica, which is of great value in detecting arthritis of lower grades, but which I have not seen described.

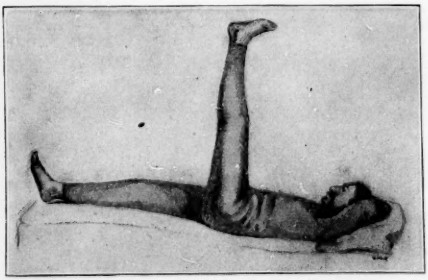

Fig. 8 (Case 2).—Arthritic side; no Lasègue sign.

For convenience of record I call it the *fabere* sign, the letters of the word standing for flexion, abduction, external rotation and extension. With the patient supine on a level surface, the thigh is flexed and then the external malleolus or ankle is placed above the patella of the opposite extended leg. In bad cases even this maneuver cannot be executed without pain, but many patients do it easily. If, however, the knee is now depressed, the ankle maintaining its position above the opposite knee, the patient will complain of pain before the knee reaches the level easily attained in normal persons.[4] This procedure involves flexion, abduction, external rotation and then extension of the thigh, and will catch more cases of arthritis of the hip than any other test with which I am acquainted. Many of the patients have quite free motion of the joint, especially flexion, and in many of them it is not easy to detect any tenderness, though firm pressure with the point of the thumb over some part of the capsule may be much more painful than on the good side. Bruce thinks that the most frequent tender point is at the upper edge of the acetabulum. Heavy percussion of the sole, or the quick shoving of the head of the femur into the acetabulum, which is almost certain to cause pain in tuberculous hip joint disease,

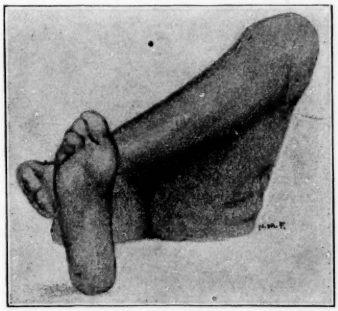

Fig. 9 (Case 2).—Arthritic side; fabere sign; knee cannot be normally depressed.

generally fails to reveal anything in these nontuberculous cases. But rare indeed is the case which will not be detected by the test described above. In making the test, one must not be deceived by the patient's yielding to depression of the knee by tipping the pelvis. This he instinctively does to avoid pain. The pelvis must remain level.

Figures 1 to 6 illustrate a case in which a woman, aged 50, complained of pain about the left hip and from the hip to the knee (Case 1). She was sent to me by one of the best surgeons in the country with the statement, among others, that a careful examination, including roentgen-ray plates, showed nothing in the hip joint. But the case was one of arthritis of the hip and, incidentally, of the left knee. Figures 7, 8 and 9 are from another case of hip arthritis (Case 2). This patient had not only free and painless flexion of the thigh, but also good abduction and rotation; and yet in this test the knee would go no lower than the point indicated in Figure 9.

It goes without saying that other tests should be used as indicated in the shoulder cases: extension,

1. A number of times I have known the sciatic nerve to be injected or stretched when the trouble was in the joint.
2. Bruce, William: Sciatica, New York, 1913.
3. Very similar to Kernig's sign. With the knee well flexed, the thigh can be fully flexed without pain; but when, with the thigh thus flexed, an attempt is made to extend the leg, it cannot be got much beyond a right angle without causing pain.
4. If the soreness has all gone from the joint and only the relics of a previous arthritis are present, there will be no pain: only inability to bring the knee down to the normal point.

flexion, abduction, adduction, rotation, strong abduction with rotation, etc., *against resistance*.

As shoulder arthritis is often accompanied by a like condition of the cervical spine, so hip arthritis frequently is complicated by involvement of the lumbar spine, and probably of the fibrous structures overlying the sacrum.[5] This may cause pain radiating down the extremity, thus assisting in the simulation of sciatica. Bruce believes that the pain down the leg is referred pain, like the pain in the knee of tuberculous hip disease.

If arthritis of the hip is present, naturally we would look for more or less muscular wasting. And this wasting, instead of being an embarrassment in the diagnosis, is an aid. Atrophy due to inflammation of the sciatic nerve of course involves all the muscles supplied by this nerve, no others, and probably the peripheral ones (leg muscles) more. The atrophy of hip arthritis, on the other hand, is found in the muscles that move the joint, especially, as Bruce has insisted, the gluteals. With the patient prone, a distinct flattening of the buttock often is apparent, and with the patient standing, a difference in the gluteal folds.

The other differential criteria distinguishing hip arthritis from sciatica may be taken over bodily from the shoulder cases. In neuritis of the sciatic nerve the Achilles jerk is diminished or lost, whereas in arthritis of the hip it is normal or, more frequently, increased. The knee jerk on the affected side is also nearly always increased. But in arthritis of the spine with considerable involvement of the nerves, these deep reflexes may be diminished.

Bruce[6] says of sciatica, "I have rarely found the tender points of the books." I entirely agree with him. The first reason is that most of the cases are not sciatica. But even in this disease the classical points of Valleix are a delusion and a snare. In arthritis, more or less tenderness on the affected side is almost the rule.

How much of this is of organic origin and how much due to the hypersensitiveness of a long-suffering patient is not always easy to say. I know that in arthritis of the hip, if one firmly punches the gluteal point, the femoral point, the popliteal point and the submalleolar point, frequently one or more of them will be or seem to be tender. But if the examiner is not satisfied with this, and proceeds to punch other places, from the iliac crest to the heel, he will find muscular tenderness, joint tenderness, tendon or fascia tenderness, sometimes even periosteal tenderness, all of which has nothing to do with the sciatic nerve.

Concerning one striking sign or consequence of sciatica, I am in doubt. This is the high degree of scoliosis or lateral curvature sometimes observed. I do not know whether this can be caused by simple arthritis of the hip, but I think that it can.

25 East Washington Street.

5. Cases thought to be lumbago with sciatica or alternation of these two affections are generally cases of arthritis of spine and hip or of the former alone.

6. Bruce, William: Sciatica, p. 11.

TORULA IN MAN

REPORT OF A CASE WITH NECROPSY FINDINGS

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Torula is a form of yeast, producing lesions preferably in the central nervous system. These lesions macroscopically simulate tuberculosis, from which disease they must be differentiated as well as from lesions formed by coccidioides and blastomycetes. It is not my object in this paper to go deeply into the differential features of these three diseases but briefly to point out the main differences and then present a case of torula infection in a man admitted to the San Francisco Hospital, September, 1916.

Fig. 1.—Low power view of lesion from cortex, several organisms seen with clear zone of gelatinous material surrounding them.

It is definitely agreed that coccidioidal granuloma and blastomycosis are two different diseases. Coccidioidal granuloma is a disease produced by an organism which sporulates but never buds in tissue. It varies greatly in size, having large forms up to 30 or 40 or even 80 microns in diameter producing many small ascospores which, in turn, escape from the capsule. It simulates tuberculosis in the type of its lesions and in the manner of spreading, principally by the lymphatics and thence to the blood stream. It is largely confined to men in the San Joaquin Valley, California. It is nearly always fatal, as no treatment has been found that is of any benefit.

The organism of blastomycosis varies in size from 3 to 20 microns. It buds but never sporulates, the buds being from one-half to one-third the size of the parent cell. It grows to the size of the parent cell before reproducing itself. It produces nodules with or without caseation, and deep and superficial abscesses with polymorphonuclear leukocytosis. It may affect all organs, including, as a rule, the skin and the bones, and it is helped by iodids. On culture mediums both the blastomycetes and coccidioides grow mycelium sooner or later. The organism of coccidioidal granuloma also produces chlamydospores at the ends of the aerial hyphae in cultures.

Years ago torulae were found to have a marked pathogenic action in animals; but prior to this case there have been only six reported in man—two by Rusk, two by Stoddard and Cutler, and one each by

Türck and von Hansemann. Torula a pseudoyeast, is distinguished from the true yeast by its absence of endospore production under all circumstances, by the fact that it never produces mycelium, that it usually does not ferment sugars, and that it reproduces itself only by budding. It is also more pathogenic for animals than is the true yeast. The central nervous system is particularly susceptible to this organism, which, however, attacks other organs less often. The pathologic changes in the meninges show a chronic inflammatory reaction with areas of caseation like tuberculosis if the lesion is extensive. The organisms, which usually occur in cells, bud in the large vacuoles enclosing them and then, as a rule, destroy the cells. The size varies from 1 to 13 microns. Small organisms may bud, the daughter cell soon attaining the size of its parent. In the older stages the organism develops a resting stage, and there is definite evidence of healing. For this reason, we may believe that the disease, while always chronic, is not always fatal and healing does occur. It is quite possible that many cases exist but are not recognized because of the obscure nature of these healed lesions. The organism possesses a definite cell membrane which stains diffusely and easily with van Gieson's stain, methylene blue and hematoxylin. In the large forms, the protoplasm is not evident. In the medium-sized, it is often shrunken into an irregular shape and takes a diffuse red stain with differential droplets. In the small forms, it fills the organism and has dark staining masses. Around the organism there is always a clear zone composed of gelatinous material. This is one of the characteristic features of the disease, for in coccidioides and blastomycosis there is no such solution of tissue. With or without caseation, nodules are formed composed of epithelioid cells, giant cells (often containing the organism) and lymphoid cells. Caseation occurs centrally, and apparently depends on the action of cell products. There are no collections of polymorphonuclear cells, and no bone or skin lesions. On culture mediums the original growth is most luxuriant on carbohydrate materials such as potato and agar or glucose agar, though scanty on blood serum. After animal inoculation, growth is more vigorous on blood serum, but better on the potato and glucose agar. Cultures continue to be viable even after years of disuse.

Fig. 2.—Same as Figure 1, under oil immersion. In left lower corner there is a very definite organism. The relative size of large mononuclear and plasma cells should be noted.

The localization of lesions in the nervous system is in the meninges, in the perivascular spaces, and in the brain substance by extension from these lesions. They have been found also in the choroid plexus, in the aqueduct of Sylvius, in and about the foramen of Magendie, and in the basal ganglions, the internal capsule, the frontal lobes and the cerebellum. Thus it may be seen that these lesions, although very small, may cause symptoms of grave importance. There is seldom fever or increase of the white count. The optic nerve may become involved, or the choked disk may be secondary to other lesions. Infection probably takes place through the respiratory tract, although it may occur through the pharynx and esophagus. Organisms are taken up by giant and large mononuclear cells, within which they continue to live and multiply, finally destroying them and becoming free. In the brain, organisms are carried along the perivascular spaces, and lesions develop peripherally in the brain substance, chiefly by solution of tissue. This ameba-like action is not as easily performed in other organs, probably because of the greater resistance of their tissue as compared with that of the brain. So we may say that the organism works in two ways: (1) mechanically, in that its growth within cells causes pressure and finally destruction, and (2) chemically, as shown by the solution of tissue. By attacking the host in the central nervous system, the organisms diminish the resistance of the patient even by small lesions critically placed.

It may be said that morphologically torula may be differentiated from coccidioides by its uniform size. It differs also in its method of reproduction, which is by budding rather than by spore formation. It resembles blastomycosis so far as the organism itself is concerned, but differs in its tissue reaction. Blastomycosis has a polymorphonuclear infiltration and no solution of tissue, while torula has this typical lysis of tissue and attracts mononuclears rather than polynuclears.[1]

The report of this case, with the pathologic findings of Dr. Ophüls, follows.

History.—E. F., aged 57, laborer, single, was born in New York, resided in California forty-five years and entered the San Francisco Hospital, September, 1916, with the diagnosis, on admission, of "second degree burn of shoulder, and senile dementia." The family history was negative. The past history was also negative, except for the fact that he had had gonorrhea twice and a soft chancre. While shaving he suddenly and without warning fell to the right, burning his right shoulder on the heater for hot water. He was able to walk, and had no great inconvenience aside from the burn. This was all the history obtainable. The burn healed satisfactorily, and he was transferred to the medical service for

1. A very complete monograph on torula, which may be referred to for further data, is that by Stoddard and Cutler: Torula Infection in Man, Monograph 6, Rockefeller Institute for Medical Research, Jan. 31, 1916.

an examination of his mental condition. While in the hospital he was quiet, and seldom spoke to any one. At times he tore the dressing off the scalded arm and threw off the bed covers. His appetite was good, and he ate in a sensible fashion. At about the beginning of the third week, he forgot to put on his bath robe when going to the toilet, and seemed distressed when asked why he did this. A few days after the appearance of these symptoms, he developed an inability to grasp objects properly or at the first reach. He would grope past them into the air. When feeding himself, he could not find his mouth easily. This was followed by a tendency to stagger forward when walking, and an inability to articulate properly. October 11, he had to be restrained in bed.

Physical Examination.—The patient was a large, strong man, restless and irresponsive. Supra-orbital pressure elicited facial response which showed no paralysis of facial muscles. The eye movements were normal. The pupils were dilated with atropin. The tongue protruded in the median line. The heart was not enlarged, showed no murmurs, and was regular in rate, the pulmonic second sound being equal to the aortic second sound. The lungs were negative except for a few râles at the bases. The abdomen was negative, as were its normal reflexes. The extremities were negative. There was a markedly stiff neck and a positive neck sign. The left knee showed a slight jerk not observed in the right. There was no clonus or Babinski. The Kernig was positive. In the examination of the eye, the fundi were normal. The blood pressure was 160.

A lumbar puncture was made, October 17, and 15 c.c. of fluid were withdrawn. The fluid, under considerable pressure, was very yellow, clear and alkaline. The Noguchi and the Nonne reactions were positive. The cell count was 488 per cubic centimeter. The differential showed all lymphocytes. The Wassermann reaction was negative. The culture on the blood serum showed no growth.

October 18, the patient was much clearer mentally, and needed less restraint. His answers were still incoherent. His condition remained about the same. The blood Wassermann was anticomplementary.

October 30, the patient was considerably worse. Examination revealed a stiff neck, and a positive Kernig sign, but no paralysis. As a second lumbar puncture was bloody, no tests were done except a Wassermann, which was negative.

November 1, fundi were negative.

November 2, the patient died, after being incontinent for urine and feces for several days.

The temperature was never more than 97, except on one day when it was 101. The pulse was from 75 to 90, and the respirations were from 20 to 25. On the patient's entrance into the hospital, the white count was 7,600; on the day before death, 15,600. The urine was alkaline, and its specific gravity was 1.020. There was a trace of albumin but none of sugar. Sediment, epithelial cells and bacteria were present.

Pathologic Findings.—A postmortem examination, done at 4:30 p. m., revealed a moderate old cirrhosis of the liver, an old thrombosis of the portal vein, marked ascites, very marked enlargement of the spleen, and numerous old scars in the kidneys, with very marked arteriosclerosis of the branches of the renal artery. There were some old scars in the upper part of the lower lobe of the left lung, and some caseous areas in the peribronchial lymph nodes. There was present also a terminal bronchopneumonia. Examination of the central nervous system revealed a tense dura somewhat thickened. The pia mater on the convexity of the brain was somewhat edematous, and showed markedly diffuse thickening. The convolutions were slightly flattened, and the dura was adherent to the pia near the median line. The large arteries at the base of the brain showed marked thickening and sclerosis. The lateral ventricles contained about 30 c.c. of clear fluid. The choroid plexus was markedly thickened and congested, as was also the ependyma of the third and fourth ventricles. The venous sinuses at the base of the brain were normal. The dura mater of the cord was somewhat thickened, and there was very markedly diffuse congestion and thickening of the pia over the entire cord. On the cut section, the cord showed a decided softening, and bulged over the cut surface. No bacteria were found in the brain or meninges.

Microscopic examination of the brain and cord revealed a marked cellular infiltration and fibrous thickening of the pia. In the pia there were numerous round encapsulated organisms resembling yeasts. Similar organisms were found in groups in the cortex of the brain, where they have caused a liquefaction of the brain tissue without much reaction. A culture taken from the cord was negative.

Microscopic examination of the peribronchial lymph glands showed numerous caseous areas and small cellular tubercles with large giant cells of the Langerhans type. In a few of these giant cells, small encapsulated organisms resembling yeasts were found.

Final Diagnosis.—This was cirrhosis of the liver; thrombosis of the portal vein; chronic splenitis; general arteriosclerosis; arteriosclerotic scars in the kidney; terminal bronchopneumonia, and torula infection of the lungs, peribronchial lymph glands, meninges and brain.

I am indebted to Dr. Ophüls for his help in determining the pathology of these tissues and to Dr. Blaisdell for the photographs.

516 Sutter Street.

THE TOXICITY OF NEODIARSENOL

ERWIN P. ZEISLER, M.D.
Instructor in Dermatology and Syphilology, Northwestern University Medical School
CHICAGO

One of the recent substitutes for neosalvarsan is neodiarsenol, marketed by a Canadian firm. It is claimed to be suitable for intramuscular or intravenous injection in either dilute or concentrated solution. I have employed neodiarsenol in dosages of 0.6 and 0.75 gm. dissolved in from 10 to 15 c.c. of freshly distilled sterile water. The powder is of a somewhat darker yellow color than neosalvarsan, and is not so readily soluble. Even after prolonged shaking there may remain small undissolved particles, which necessitates filtration.

In a recent series of twenty intravenous injections given to fifteen dispensary and private patients in all stages of syphilis, I have noticed an unusually large percentage of reactions. Ten of the patients complained of varying degrees of nausea, vomiting, headache and fever for from twenty-four to forty-eight hours after the injection. One woman with a fresh syphilitic infection (roseola, adenopathy and a positive Wassermann reaction) five days after the administration of 0.6 gm. of neodiarsenol developed fever, headache, vertigo and incessant vomiting which lasted twelve hours. In the absence of any other explanation, I was forced to conclude that this was a late toxic manifestation, possibly an encephalitis. The patient recovered under rest in bed. Another patient in the midst of the injection complained of nausea, faintness and thoracic oppression, with marked flushing of the face. He was immediately given a hypodermic of epinephrin and was able to go home half an hour later. Another patient with symptoms of early tabes collapsed a few minutes after the injection, became extremely pallid, and his pulse became almost imperceptible. The immediate reaction in this case was most alarming, but fortunately he recovered. A very obese patient on account of technical difficulties received 0.6 gm. of neodiarsenol intramuscularly. The pain and local reaction were so intense as to require morphin injections for the next forty-eight hours.

On account of these unpleasant experiences I have abandoned the use of neodiarsenol, and have since then employed the French preparation, novarsenobenzol (Billon), which has given satisfaction.

30 North Michigan Avenue.

Clinical Notes, Suggestions, and New Instruments

TRANSFUSION OF IMMUNIZED BLOOD FOR CHRONIC BACTEREMIA: REPORT OF A CASE

HENRY P. WEKESSER, PH.G., M.D., LINCOLN, NEB.

History.—Miss J., aged 22, a nurse, whose family and early history were negative, developed tonsillitis a few days after having attended a patient whose illness began with acute tonsillitis and terminated in a fatal pneumonia. Cultures from the throats of both the nurse and her patient showed mixed infections, and diphtheria antitoxin was used along with the other treatment.

When the nurse came under my care she had been sick about seven months, during which time one complication had followed another, indicating that never during that time had she been entirely free from the original infection. When the throat infection began to improve, she developed a purulent inflammation in the left antrum of Highmore, which was promptly drained through the nose. Following this infection, all the larger joints of the body became inflamed. During the latter part of the first of several attacks of general arthritis, endocarditis developed. In the treatment of the patient, autogenous and stock vaccines had been used along with drugs and other hygienic measures.

When the patient came under my care, there was still some discharge from the antrum, though the joint invasion had apparently subsided. But the rapid pulse, irregular daily chills followed by fever and sweating, spells of dyspnea with cyanosis, swelling of the ankles, enlargement of the heart, loud systolic murmur at the apex, and a dry hacking cough indicated that the endocardial infection was still active and possibly ulcerative in character. Smears from the antral discharge revealed a predominance of diplococci resembling the pneumococcus. Blood cultures also revealed the same organisms in pure culture.

Rest in bed, drugs, ice over the cardiac region, etc., were ineffective.

Treatment by Transfusion.—Since all other known methods of treatment had been tried, the following plan was devised: A vaccine was prepared from a culture made from the patient's blood. From five to seven doses of this vaccine were administered hypodermically in six-day intervals to four volunteers of about the same age as the patient. Their blood was first thoroughly examined (including the Wassermann test) and tested against that of the patient. In order to immunize them against the patient's infection, the volunteers were vaccinated as needed, and from 250 to 500 c.c. of blood were transmused from an immunized donor to the patient in ten to fourteen-day intervals. More blood was not given at one time because of the cardiac weakness of the patient. In all, six transfusions were made.

Blood cultures were negative after the second transfusion. Chills and fever gradually ceased, and the patient became stronger and was able to leave her bed and even walk a little, two months after the first transfusion.

Although physical signs still indicate an insufficient mitral valve, the patient has again resumed nursing, ten months after the first transfusion.

COMMENT

Whether the endocardial process was simple or ulcerative cannot be proved. The anemia and blood infection disappeared rapidly after the first transfusion. Our present methods of preparing autogenous vaccines make this method safe. Also, it is certainly more rational than the use of vaccines in the treatment of chronic blood infection.

Military Medicine and Surgery

SEXUAL INFECTIONS IN CANTONMENTS AND CAMPS

A FOLLOW-UP SYSTEM FOR THEIR CURE AND CONTROL

JAMES BAYARD CLARK, M.D.
Major, M. R. C., United States Army
NEW YORK

This system, which has been installed in Camp Lee, Va., has three distinct objects in its pursuance:

First, a running record on cards that reflects in outline the entire activity of the genito-urinary service at the base hospital.

Second, a means by which all patients can be observed and their record continued after discharge from the base hospital.

Third, and most important, a method of restriction from any absence from the reservation of all infected patients until on examination such patients are found free from further infectiousness and can safely be allowed a pass to leave the confines of the camp.

The simplicity of this system is best illustrated by the printed forms, which are here shown in the order of their employment.

FORM 1

Genito-Urinary Service, Base Hospital, Camp Lee, Va.

Surname Christian Name Rank Co. Regt.

Diagnosis Duration

Condition on Admission (.. 19..).

Remarks

Condition on Discharge (.. 19..).

To return.

Form 1, a card form, is filled in from the ward records of the patient on discharge from the hospital.

If the patient is discharged as cured, the case is considered as complete and the card placed in the permanent filing case. If the patient is not cured,

FORM 2

Base Hospital, Chief of Genito-Urinary Service, Camp Lee, Va.

From: Chief of Genito-Urinary Service

To: Regimental Surgeon .....

Subject: Treatment of patient on discharge from Base Hospital.

1. The following treatment is recommended in the case of

..... Rank Name Rank Co. Regt.

2. It is requested that this man be directed to report to me for examination,

operation, on ..... 19.., at ..... M.

treatment,

..... Major, Med. Res. Corps.

the date and hour for the patient's return for observation is noted on the card, and the card is placed in an envelop, on the upturned flap of which is written the date of return for this patient. The envelop is then placed in a temporary file according to the date, with the flap up, so that from this calendar-like file as the days come round the envelops

are taken out and the cards reveal which patient or patients are to return that day for observation, treatment or operation, as the case may be. When a patient is cured, and the case closed, the card goes back to the permanent file; otherwise it continues running in the calendar file until completed. The subsequent notations when the card is filled are written on a plain card headed by name, rank, etc., and fastened to the original card.

Letter Form 2 is filled out and sent off at the same time the card form is started, that is, when the patient is discharged from the base hospital and returned to the care of his regimental surgeon. This letter form is also used on all subsequent visits to the base hospital by the patient, when it is desirable that he should return.

FORM 3

Base Hospital, Office of Genito-Urinary Service, Camp Lee, Va.

From: Chief of Genito-Urinary Service

To: Commanding Officer, ... Co. ..... Regt.

Subject: Failure of patient to report.

1. Your attention is invited to the fact that

..... Name Rank Co. Regt.

has not reported for ..... on .....

19... ..... M., as requested in letter to Regimental Surgeon ..... 19...

.....
Major, M. R. C.

Letter Form 3, it need hardly be mentioned, will be but rarely required. Its wording, however, will suggest the moment of its usefulness.

Forms 4, 5 and 6 work rather independently of those just described.

FORM 4

Base Hospital, Office of the Genito-Urinary Service, Camp Lee, Va.

From: Chief of Genito-Urinary Service

To: Regimental Surgeon .....

Subject: Control of infectious cases of venereal disease.

1. The enclosed forms in numerical sequence are for use in cases of venereal diseases under your care, and are self-explanatory.
2. These forms are to be used in all cases of venereal disease, which had occurred since the opening of this cantonment, and are to be continued in use in all subsequent cases.
3. These forms will be issued from this office in such numbers as you may require.

.....
Major, M. R. C.

These cards with return envelops are sent (a small number of each) to each regimental surgeon, along with the letter of instruction as to their application.

The numbers of the cards and the surgeons they are sent to are first carefully noted in a book kept for that purpose, and all subsequent cards sent out are likewise kept track of, to be checked up, first when the examination is made and finally again when the cards come back.

It has seemed wise to have all patients with sexual infection in camp report to some one center, well equipped with laboratory facilities and specially trained men, and here pass that important final judgment as to whether the patient is free from infectiousness and can with safety be allowed to visit the civil community.

If the civil communities will do as much to protect the soldiers in this respect as the military is doing to protect civil populations, they will do much not only toward shoring up their own social structures, but also toward shortening the war.

A brief study of these cards will make their function and significance plain, both as a check on the infectious soldier, and as a complete record of all such cases in a camp taken from a different angle than are the present military reports.

It has been mentioned that the latter set of forms works rather independently of the former, and this is necessarily so, as a large proportion of sexually infected soldiers are cared for by their regimental surgeons and do not come to the base hospital at all; however, this plan of having every man come to one central bureau for his final examination is of much importance, as it not only brings the regimental surgeon and the base hospital surgeon into a closer and more purposeful cooperation in reaching a higher standard, but also increases the respect of the soldier in the vitally important subject of a sexually clean bill of health.

If what many are seeking to make us believe today is so, that there is more loss of service in the armies of our allies through sexual infections than through the usual wounds of war, then to the Medical Corps of our Army there comes a warning not to be lightly laid aside, and to the medical officer whose duty includes the care and control of sexual sickness there comes a singular responsibility, for in the manner of his doing, it may be that the balance of man power in the final struggle of this war shall be determined.

FORM 5

CAMP LEE, VA.

No.....

From Surgeon .....

To Commanding Officer ..... Co. ..... Regt.

You are hereby informed that .....

is infected with .....

Attention is invited to the C. of O. 1881-1915, Par. 92, subsection 3, page 214, which states that "while in the infectious stages the men should be confined strictly to the post."

The above soldier should not be given leave of absence from the reservation until, upon examination, no further evidence of infectiousness can be found, and the *attached* card is signed by surgeon of the Genito-Urinary Service.

This card is to be retained by Company Commander until card of examination is signed and returned to him, at which time he is requested to return both cards to the Genito-Urinary Service, Base Hospital.

.....

GENITO-URINARY SERVICE

No.....

BASE HOSPITAL, CAMP LEE, VA.

Name ..... Rk. ..... Co. ..... Regt.

shows no further evidence of infectiousness from.....

....., and is discharged from further treatment.

.....Major, M. R. C.

Base Hospital.....19 , ...

Before any leave of absence can be obtained following above examination, this card is to be taken by the soldier to his Company Commander.

ENVELOP FORM 6

WAR DEPARTMENT PENALTY FOR PRIVATE USE $300.

From Commanding Officer

Co. Regt.

.....

Official Business.

For return of card No. *XXX*

To Chief of Genito-Urinary Service,
Base Hospital,
Camp Lee, Va.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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SATURDAY, DECEMBER 29, 1917

THANK YOU

In response to the note in last week's issue of THE JOURNAL, a large number of remittances for Fellowship dues and subscriptions for the ensuing year have been received. No doubt at this time many are at the point of remitting. For the convenience of those who may have misplaced the slip enclosed in last week's issue, another is inserted in this number. Those who have already remitted will of course ignore the slip in this issue.

RECENT WORK ON GASEOUS GANGRENE

Recent investigations have added greatly to our knowledge of gaseous gangrene. To determine whether the conditions currently designated as gaseous gangrene are associated with the same or with different bacteria, Weinberg and Seguin[1] made an exhaustive bacteriologic study of ninety-one cases of gangrene. They found anaerobic bacteria in the wound in every case, occasionally just a single anaerobic species, occasionally several anaerobes in association; but in the majority of the cases several different anaerobes and aerobes were present. This result might be taken to indicate that no one bacterium plays a predominant rôle in the development of gaseous gangrene, and consequently that the outlook for a specific treatment based on a definite and constant etiology is not promising. It is highly significant, however, that the most common anaerobe by far in this series, being present in two thirds of the cases, was *Bacillus welchii,* also called the gas bacillus, or *B. perfringens,* as the French call it. Next in frequency came a bacillus which is called *Bacillus oedematiens,* and then the *vibrion septique* of Pasteur, or the bacillus of malignant edema. Probably these two organisms are closely related. In the cases with abundant gas production, extensive crepitation, bronzing of the skin, etc., that is, the classical form of gaseous gangrene, *B. welchii* was the dominating organism, while *B. oedematiens* (bacillus of madignant edema) predominated in certain toxic cases with progressive edema; but cases of mixed infection with both these bacilli were observed also. The investigations of Weinberg and Seguin emphasize, consequently, that in gaseous gangrene, that serious complication of war wounds, *B. welchii* is by far the most important organism. Injured muscle, exposure of bone marrow and interference with the circulation on account of arterial injury, tight splints and casts are conditions that favor the growth of this bacillus, infection with which is bound to occur with great frequency because it is in the soil and on the skin and clothes of the soldiers, especially those in the trenches. Laying wounds open and cleansing them thoroughly, removing all foreign materials and damaged tissue, naturally will cut short many cases; while in many others the invasion of the bacilli and the resulting general intoxication rapidly pass beyond arrest and cure even by the most skilful and thorough local treatment, and demand new and more subtle methods.

Probably the decisive step toward finding one such method already has been taken. Weinberg and Seguin[1] urge the use of antitoxic serums which they have prepared against the three most important anaerobes concerned in gaseous gangrene, but we as yet know practically nothing of principles and methods they have followed in developing these serums. In earlier communications, Weinberg[2] states that antitoxic serums have been secured from the horse against *B. oedematiens* and *vibrion septique,* and antibacterial serum against *B. welchii* (*B. perfringens*); but no exact description of the methods used is given. In the meantime, Bull and Pritchett,[3] whose work has been discussed in these columns before, laid a sound experimental basis for antitoxic serum treatment of infections with *B. welchii* by showing that when this bacillus is grown in broth with sterile rabbit muscle a typical toxin is produced, which in the guinea-pig causes symptoms typical of the infection, and which in suitable animals evokes the elaboration of a specific antitoxin with both protective and curative properties under experimental conditions. The discovery that *B. welchii* produces a true toxin places it in the same group as *B. diphtheriae, B. tetani* and *B. botulinus.* DeKruif, Adams and Ireland,[4] as well as Bull,[5] find that the toxin produced by various strains of *B. welchii* is neutralized by the same antitoxin, which would indicate that if the natural infection can be influenced by antitoxic serum, one and the same toxin may serve as the antigen in the process of immunization. DeKruif and Bollman[6] further show that acid plays no part in the intoxication produced by *B. welchii,* as asserted by earlier workers, and thus support the view

1. Weinberg and Seguin: Etudes sur la gangrene gazeuse, Ann. de l'Inst. Pasteur, 1917, **31**, 442.

2. Weinberg: Proc. Roy. Soc., 1916, **9** (occasional lectures), **119.**
3. Bull and Pritchett: Jour. Exper. Med., 1917, **26**, 119.
4. DeKruif, Adams and Ireland: Jour. Infect. Dis., 1917, **21**, 580.
5. Bull, C. G.: Jour. Exper. Med., 1917, **26**, 603.
6. DeKruif and Bollman: Jour. Infect. Dis., 1917, **21**, 588.

of Bull and Pritchett, that a true toxin is the essential factor in the general intoxication.

From the foregoing it appears that *B. welchii* is a toxicogenic bacterium, and that it is the most important bacterium concerned in so-called gaseous gangrene; that other anaerobic bacteria, the mechanism of the infection with which we do not understand as well, may also be concerned, and that the stage is now set for the treatment of gaseous gangrene with antitoxic serum. The outcome will be watched with much interest.

THE CEREBROSIDS OF THE BODY

Only a few years have passed since the so-called lipoids were regarded as essentially characteristic of nervous tissue, from which some of them were first prepared in amounts adequate for careful study. Subsequent investigation demonstrated a far more widespread distribution of these fatlike organic substances in tissue of the most diverse sort, in both the animal and the plant kingdoms. The lipoids, or at least representatives of this somewhat heterogeneous group of compounds, are today looked on as important constituents of living cells in general; and they appear to play a prominent part in the structure and function of the cell membranes. Their physical properties are quite unlike that of the ordinary water-soluble components of tissues; and the unique character of their chemical composition suggests important functions of a chemical nature, whatever they may be.

Among the lipoids the phosphatids, a group including lecithin and kephalin, have received the most attention. The assumed and possible relations of these substances to various physiologic and pathologic phenomena have frequently been discussed in THE JOURNAL. Only recently kephalin has come into unanticipated prominence, owing to its presumable rôle in the reaction of blood coagulation.[1] Lecithin is being brought into relation to the metabolism of the fats, especially through the researches of Bloor. Cholesterol, long familiar as a conspicuous constituent of the brain and a component of gallstones, likewise has acquired a new prominence in connection with the blood. Less well known is that group of lipoids to which the designation of cerebrosids has been given. The pioneer worker on this type of substances was Thudichum,[2] who assumed the existence in brain tissue of at least two different compounds characterized by yielding, on decomposition, the sugar galactose together with a nitrogenous base, sphingosin, and a higher fatty acid.

Thus the names of two cerebrosids, phrenosin and cerasin, entered the literature of physiologic chemistry in connection with the study of the composition of the brain. Phrenosin yields cerebronic acid, whereas, from cerasin, lignoceric acid has been obtained. Not only have the cerebrosids now been found in other organs than the nervous system, but there appears to be an identity of these lipoid substances in the several tissues, just as has been found true of other lipoids. Levene and West[3] have lately demonstrated that the cerebrosids in egg yolk, the liver and the kidney seem to be identical with those obtained from the nerve tissue. They yield the same sugar, galactose, the same base, sphingosin, and the same fatty acids, lignoceric and cerebronic. It is not certain whether the two cerebrosids, phrenosin and cerasin, occur in the same proportions in nerve tissue and in the various other organs. This uncertainty applies, however, to every other individual lipoid. It is quite possible, as Levene and West remind us, that the proportions of the lipoids vary with the variation of the organ. Certainly it represents a distinct step in advance to have more intimate knowledge of the chemical compounds with which the performances of our body cells are inevitably concerned. Metabolism, immunity, heredity are merely words that express in an as yet indefinable way the chemical manifestations bound up with the performance of compounds at present unidentified — possibly the very substances that these newer lipoid researches have helped to elucidate. Studies in this field are attended with enormous difficulty; they should be encouraged all the more because of the great promise which the successful invasion into its secrets holds out.

URIC ACID AND GOUT

It would be impolitic and essentially wrong, Otto von Fürth[4] wrote a few years ago in relation to gout, simply to ignore whatever judicious objective observers have found appropriate after decades of study, merely because no theoretical explanation has been found. It should never be forgotten that the observations of the practitioner may be true and the theories may be false, and that a judicious natural scientist generally values the former more than he does the latter. Unfortunately, objective observation, especially in the treatment of chronic internal affections, is endless and difficult; and for that very reason this has been and will be at all times and among all people the favorite field for both scientific and unscientific charlatanry.

Assuredly, therefore, we need to secure the attainable scientific facts regarding gout, and particularly its much discussed relation to uric acid, with which it has been prominently associated ever since Garrod's studies in 1848. Garrod's contention, that the bloody of gouty persons is characteristically richer in uric acid than is the circulating medium of normal persons, long ago

1. The Hemostatic Action of Kephalin, editorial THE JOURNAL A. M. A., Nov. 4, 1916, p. 1373.
2. Thudichum, J. L. W.: Physiological Chemistry of the Brain, London, 1884.
3. Levene, P. A., and West, C. J.: Cerebrosides, V, Cerebrosides of the Kidney, Liver, and Egg Yolk, Jour. Biol. Chem., 1917, **31**, 649.
4. Von Fürth, Otto: Chemistry of Metabolism, translated by A. J. Smith, Philadelphia, 1916, p. 193.

awakened inquiry as to the cause of this phenomenon. The accuracy of the observations might well have been debated up to a few years ago, when microchemical methods of analysis greatly simplified the determination of the facts with comparative ease on a larger number of patients. At present it seems to be agreed that the gouty show an increase of uric acid in the blood. The latest report[5] in this field, reviewing the situation, concludes that on statistical evidence more than 3 mg. of uric acid per hundred c.c. of blood, with the patient on a purin-free diet, is a symptom of gout, but is not a diagnostic sign of the disease.

Is this increase of uric acid in the blood of gouty patients to be ascribed to either an increased entrance or a diminished escape of the material? At present there is little reason for postulating an increased genesis of uric acid in gout, although such a theory was popular a few years ago. There can be no question, however, of occasional delayed excretion of uric acid by the gouty. It was quite natural, therefore, to correlate the uric acid stagnation with defective renal function. When no clear indications were discernible, a "latent" nephritis was sometimes postulated in explanation of the "gouty diathesis." Today the possibility of applying functional tests to the kidney makes a vague explanation of this sort scarcely justifiable. It is not easy to distinguish cause and effect in the alleged association of gout and nephritis. In their investigations at the Peter Bent Brigham Hospital in Boston, McClure and Pratt have become convinced, like others before them, that although in the majority of gouty patients there are increased amounts of uric acid in the blood, a large percentage do not have markedly increased quantities of other nonprotein nitrogenous substances in their blood when on a purin-free diet. Indeed, they categorically state that a marked retention of nonprotein nitrogen is not frequent in gout.

It was to be expected that considerable light might be thrown on the meaning of the augmented uric acid in the blood if the fate of exogenous purin-yielding foods in gouty subjects could be ascertained. Human patients alone suffice for this purpose, since, in the common laboratory animals, in contrast with man, uric acid is further oxidized in the body. McClure and Pratt have followed the effects of injections of uric acid, and of the ingestion of purin-forming products, in man. Their results, along with previously known facts, indicate that in normal and nongouty as well as in gouty persons there is great variability in the quantity and in the duration of exogenous uric acid excretion. For this reason, they say, a diminished or a protracted exogenous uric acid output most probably results from factors other than disturbances in the purin intermediary metabolism. If this is not true, then derangements in purin metabolism are so common that their importance in the etiology of any diseased condition is problematic.

If the failure to eliminate exogenous uric acid promptly is not peculiar to gout, though it would appear to occur more frequently in gouty than in nongouty persons, we may assume, with the Boston investigators, that the acid enters the body tissues in some way, since it is not known to be destroyed in the body. For the moment, in attempting to make a diagnosis it is perhaps preferable to depend on the analysis of the blood rather than on the failure to excrete exogenous uric acid promptly.

5. McClure, C. W., and Pratt, J. H.: A Study of Uric Acid in Gout, Arch. Int. Med., October, 1917, p. 481.

CREATINURIA

The excretion of creatin in the urine is a phenomenon now generally recognized to occur at times in normal persons. The intake of a very large quantity of creatin may lead to some elimination of this compound; but creatinuria occurs in healthy persons under conditions that are not referable to such a cause. Normal men do not excrete creatin through the kidneys under usual conditions of diet. Normal children, however, are now recognized to excrete creatin commonly during the period of adolescence. This was demonstrated in this country several years ago by W. C. Rose[1] at Yale University and verified by Folin and Denis[2] at the Harvard Medical School. Subsequently Krause[3] showed that the younger the child, the less its ability to retain creatin administered by the mouth. These observations have been puzzling to the physiologist and have led to a variety of hypotheses as to the unexpectedly unlike behavior of the juvenile and the adult organism, respectively, in the matter of spontaneous creatinuria. The problem was seemingly further complicated by the statement of Krause[4] that the urine of normal women frequently contains small amounts of creatin. This creatinuria, according to Krause, is associated with the sexual cycle, and is always present after menstruation; and while in some individuals it may disappear during the intermenstrual period, in others it persists.

The facts regarding creatinuria in children remain unchallenged. With respect to the possibility in women, Mary S. Rose[5] has reinvestigated the subject quite extensively over longer periods of time on a number of adult women. She reports that the creatin output of women is very irregular, and no definite relationship between creatin and creatinin has been demonstrated. There is no clearly defined connection between the creatin output and the sexual cycle. Creatin tends to disappear at the onset of menstruation and to reappear shortly afterward, but it may do the same at other times also.

1. Rose, W. C.: Jour Biol. Chem., 1911-1912, **10**, 265.
2. Folin, O., and Denis, W.: Jour. Biol. Chem., 1912, **11**, 253.
3. Krause, R. A.: Quart. Jour. Exper. Physiol., 1914, **7**, 87.
4. Krause, R. A.: Quart. Jour. Exper. Physiol., 1911, **4**, 293.
5. Rose, Mary S.: Creatinuria in Women, Jour. Biol. Chem., 1917, **32**, 1.

In previous issues of THE JOURNAL we have discussed the current hypotheses regarding creatin and creatinin excretion. The theories that creatinuria is an accompaniment of inadequate carbohydrate metabolism induced either by dietary deficiencies or by disease, or that it is a consequence of a condition of acidosis, have been found inadequate to explain all cases in which creatin is excreted. More recently the reference of creatin elimination to a high level of protein metabolism has been revived as a working hypothesis. Thus Denis[6] found that forced protein feeding induces creatinuria in certain cases of hyperthyroidism, whereas a low protein diet produces a creatin-free urine. She has reported similar results also from varying the protein intake of children.

Denis and Minot[7] found it possible, in experiments on two normal women, to cause creatin excretion by feeding a high protein (creatin-free) diet, and to cause the creatinuria so produced to disappear by the consumption of a low protein diet. In two men to whom a similar experimental procedure was applied, Denis and Minot were unable to produce creatin excretion even when a sufficient amount of protein was consumed to cause the urinary nitrogen to rise to 34.5 gm. per day.

This contrast in the apparent behavior of normal men and women toward the same diets, with respect to the creatin output, argues for some distinct difference in their metabolic capacities. There are, however, apparent conflicts in the data available. In her observations on women, Rose[5] found not only that creatin is excreted on diets liberal in carbohydrate and causing no acidosis, but also that the excretion is not definitely influenced by the amount of protein in the diet. She therefore inclines to the view, to quote her own words, that creatin is constantly being formed in relatively large amounts and is normally for the most part either utilized or destroyed; that the adult man can metabolize considerable amounts, while the child's powers are much weaker, so that creatin in the latter represents a balance between formation and destruction; and that women occupy a position intermediate between men and children, being able to metabolize most if not all of the creatin that they may produce, the amount fluctuating with perhaps a variety of conditions. Without venturing any more detailed hypothesis, Denis and Minot repeat the suggestion that the ease with which creatinuria can be induced in normal women may be due to their relative lack of muscular development as compared with that of man. No explanation yet offered will permit a satisfactory interpretation of the now available facts; but the way to an understanding is unquestionably being made more easy by the increasing number of observations under well controlled conditions of diet.

6. Denis, W.: Jour. Biol. Chem., 1917, **30**, 47.
7. Denis, W., and Minot, A. S.: The Production of Creatinuria in Normal Adults, Jour. Biol. Chem., 1917, **31**, 561.

Current Comment

EXPLOITING CHICAGO'S FOREIGN BORN

Four years ago the Chicago *Tribune* published a series of articles dealing with practically every advertising quack in the city of Chicago. In preparing the series it assigned to some of its reporters the task of investigating the local quack industry, and the reporters performed their tasks well. As a result of the light turned on this business, those English-language newspapers of Chicago that had heretofore offered a welcome haven to the quacks threw out this entire line of advertising—and kept it out. Quackery, however, was not dead in Chicago. One by one the fakers came back and adapted themselves, as quacks will, to the changed conditions. Chicago has a tremendously large foreign population, and is publication headquarters for a great many foreign-language newspapers. These the quacks patronized—and the papers have, apparently, been willing accomplices. Now the *Tribune* is publishing a second series of articles on the quacks. As in the previous campaign, a reporter has been paying visits to the various quacks, this time in the rôle of a foreign-born citizen. History is repeating itself. It remains to be seen whether the foreign-language press of Chicago can be shamed into the same action that some English-language newspapers took four years ago. If they can, the more blatant quacks of Chicago will have received a body blow, for only with the connivance of newspapers can these scoundrels ply their trade. The foreign-language press of the country professes to stand as champion of the foreign-born Americans. If this attitude is not a pretense, their course in the present matter is clear.

ULTRAVIOLET LIGHT AND BACTERIA

To understand something of the action of ultraviolet light in contrast with ordinary spectral light in relation to living structures, it must be borne in mind that the greater number of the constituents of living cells are colorless, that is, they do not absorb rays of the wave length of visible light. As many of them absorb ultraviolet light, however, the possibility of effects on living cells is thereby afforded. Sunburn (erythema solare) is a familiar illustration of inflammation due to the effect of ultraviolet light on the skin. Severe conjunctivitis also is caused by this agency, unless the eyes are protected by spectacles that are impermeable to the short waves. This danger is appreciated in electric welding, in which the arc spectrum of iron sends out the ultraviolet rays. The effects of this form of light do not extend far into more complex organisms because the absorbing power of protoplasm for ultraviolet rays is very considerable. When a better opportunity for penetration is given, as in small organisms like bacteria, a destructive effect is readily manifested. Hertel showed this in 1905; and subsequently Henri and his co-workers in Paris extended our knowledge of what has been called the abiotic action of ultraviolet light. Usually the microorganisms have been exposed in the presence of nutrient culture mediums in order that the destructive

effects might be studied. These evidently offer considerable protection against ultraviolet rays.[1] At the Henry Phipps Institute of the University of Pennsylvania, Newcomer[2] has recently found that when the micro-organisms are suspended in water the baneful effect of the rays is far more obvious. Exposures to iron, zinc and copper sparks were tested. The killing power of ultraviolet light, in the case of typhoid bacilli studied by Newcomer, begins to decrease at about 2,800 Ångström units; and in the spectral region where the sun's rays begin, the sensitivity is practically nil. Typhoid bacilli unprotected by absorbent mediums are about one two-hundredth as sensitive to ultraviolet light of wave lengths from 2,100 to 2,800 Ångström units as is the photographic plate.

CHANGES IN THE PURGED INTESTINE

The postoperative lethargy of the bowel, the nausea and the apparent inertia of intestinal movement following a laparotomy form a picture familiar to every clinician. This sluggishness with its attendant gas pains, vomiting, etc., is one of the prominent symptoms of distress that usually persists for a time after operations, and challenges the efforts of the physician directed toward its relief. As a preliminary to operative procedures, it is a widespread custom to prepare the patient by purging. The staff of the George Williams Hooper Foundation for Medical Research at the University of California Medical School has made a direct test of the physiologic effect of purgation on the condition of the bowel[3]. It seemed reasonable to suppose, they state, that if purgatives have either a tonic or a depressant effect on the intestine, these effects should be demonstrable in excised segments beating in a suitable medium. Furthermore, if the treatment with purgatives should happen to leave some region of the intestine more fatigued or more irritable than others, the orderly progress of peristaltic phenomena might be interrupted. Alvarez and Taylor, who conducted the experiments on animals, thus state their findings:

> The well purged rabbit is likely to be apathetic and to look sick. Its bowel is full of gas and fluid, and the mesenteric circulation is disturbed. Excised segments beat poorly and irregularly in Locke's solution, and they fatigue quickly. They respond poorly to drugs. Some parts of the bowel are abnormally irritable, while others fail to respond at all to powerful stimuli. This unevenness in the gradient of muscular forces must interfere with the steady progress of food through the gut; and it probably favors the production of colic and gas pains.

Calomel and cascara did not seem to poison or fatigue the segments of the intestine, as did castor oil, magnesium sulphate and jalap. The investigators conclude on the basis of their experimentation with animals that it is not wise to purge shortly before an operation in which the bowel must stand drying, handling, cutting and sewing. The surgeon may well give some heed to this suggestion, at any rate to the extent of carefully weighing the reputed advantages of preoperative purgation against the detriment suggested by these studies.

1. Browning, H. C., and Russ, S.: Proc. Roy. Soc. London (B), 1917, **90**, 33.
2. Newcomer, H. S.: The Abiotic Action of Ultraviolet Light, Jour. Exper. Med., 1917, **26**, 841.
3. Alvarez, W. C., and Taylor, F. B.: Changes in Rhythmicity, Irritability and Tone in the Purged Intestine, Jour. Pharmacol. and Exper. Therap., 1917, **10**, 365.

PHENOLSULPHONEPHTHALEIN IN DIAGNOSIS OF DISEASE OF THE CENTRAL NERVOUS SYSTEM

Until quite recently, the textbooks have been singularly reticent about the functions of the cerebrospinal fluid. It has long been known that there may be an exchange of constituents between the cerebral sinuses and the blood stream; but the paths of transference have been a subject of some uncertainty. The debate has in part hinged about the question as to whether the spinal fluid is merely a sort of lymph bathing the nervous tissues and directly communicating with the rest of the lymphatic system, or whether it represents a secretion of special character and different origin. In any event, it is well understood that foreign water-soluble substances introduced into the cerebrospinal fluid find their way into the general circulation, from which they can subsequently be excreted by the kidneys. Thus Dandy and Blackfan[1] showed that phenolsulphonephthalein, which has been used widely as a test of renal function, is harmless when injected into the subarachnoid space, and appears in the urine in normal infants in from four to ten minutes. They employed the test pigment in a study of hydrocephalus. It has more recently been employed by Mehrtens and West[2] at the Leland Stanford Junior University School of Medicine, to determine, if possible, whether there might be some disturbance in the excretion of phenolsulphonephthalein in diseases of the central nervous system other than hydrocephalus. One naturally thinks in this connection of disease characterized by meningeal inflammation. Thickening and edema are common involvements of the vascular system and membranes of the nervous system. The California investigators have found that phenolsulphonephthalein injected into the subarachnoid space in normal persons appears in the urine in ten minutes or less. Diseases of the central nervous system, especially when involving the meninges, produce a lengthening of the appearance time to as much as seventy minutes in some cases. This delay cannot be accounted for by disease of the kidneys, or by the reduction of the phenolsulphonephthalein in the spinal fluid. In syphilis a lengthening of the appearance time may be produced before any other evidence of central nervous system involvement has appeared. An example is afforded by clinical tabetics, who furnish meager pathologic findings through examination of the spinal fluid, yet may exhibit a great delay in the excretion of the dye. Admitting that advanced general arteriosclerosis may be a factor in causing the delay in some instances, the method indicated is nevertheless of considerable significance in a diagnostic way because it may facilitate detection of organic disease when the ordinary spinal fluid findings are negative or incomplete.

1. Dandy, W. E., and Blackfan, K. D.: Internal Hydrocephalus, Am. Jour. Dis. Child., December, 1914, p. 406.
2. Mehrtens, H. G., and West, H. F.: The Absorption of Phenolsulphonephthalein from the Subarachnoid Space in Diseases of the Central Nervous System, Arch. Int. Med., October, 1917, p. 575.

Medical Mobilization and the War

NAVAL DENTAL RESERVE FORCE FULL

The Surgeon-General of the Navy announces that the Navy's needs, so far as dentists in the Naval Reserve force are concerned, are more than satisfied, and that no applications are receiving favorable consideration at present.

RED CROSS COMMISSION ON WAY TO ITALY

The permanent Red Cross Commission for Italy, which is to take over the relief work begun by Major Murphy, has sailed for that country. Robert P. Perkins, New York, is in charge of the commission, and Dr. Joseph Collins, New York, is one of the members. Major Murphy has cabled that it has been necessary to place contracts which have practically used up the $250,000 which the Red Cross appropriated for relief work in Italy, and has requested an additional $250,000. He states that there is a great deal of work to be done, as the German successes in Italy involved the destruction of many military hospitals.

COMMITTEE VISITS ITALY

On the recommendation of Surgeon-General Bradley, General Pershing appointed a committee to study hospital conditions, surgical treatment and sanitary medicine in Italy. The committee consisted of the following members: Majors Angus McLean, George E. McKean and Harry N. Torrey. Lieut. Bror H. Larsson accompanied the expedition as secretary, and Capt. James W. Inches represented the American Red Cross. Permission for this investigation was obtained through the Italian military authorities, and was granted for fourteen days.

NEWS OF THE CANTONMENTS

Thirty-Fourth Division, Camp Cody, Deming, N. M.

DEC. 21, 1917.

RED CROSS

This organization was authorized by Act of Congress in January, 1905, to be a "medium of communication between the people of the United States and their Army. . . . No volunteer aid from any society or association will therefore be accepted for the Army of the United States except through the American National Red Cross."

An office and store room has been established at each of the large camps for the purpose of adding in any possible way to the comfort and happiness of the men, and of helping with supplies prepared in advance for any emergency that may arise. If needed, these supplies are given freely through the division surgeon without any charge, request being made by the Red Cross merely for a receipt, which can be used as a voucher in connection with the return of property made by the local representative. Such donations are made for enlisted men only, officers being able to provide for themselves. But the War Department has looked so carefully after the needs of soldiers that thus far its forethought has prevented any considerable requirement on the Red Cross, whose watchful representative has usually been able to find very few needs left uncared for.

Mr. Edwin H. Brown of Minneapolis is the representative at Camp Cody, and like all other field directors his services are given without salary or remuneration from any source. No agent of the Red Cross at this camp is in receipt of any salary. Through this office there have been received to date and for the most part distributed 4,785 woolen sweaters; 4,705 woolen wristlets; 2,304 woolen mufflers; 2,598 woolen socks; 43 woolen helmets; 1,000 goggles; a Pathé phonograph to the base hospital; 65 clinical thermometers, and an electric heater to the base hospital.

At this season a particularly grateful function of this "medium of communication between the people of the United States and their Army" is the distribution of Christmas packets. Enough have come from the homes of America to provide one for each man, carrying not only its own cheer into the camp Christmas, but also the home love and ideals, which are the foundation of American character and strength.

SCHOOLS, MEDICAL DEPARTMENT

Four of these are now in operation. 1. The school for medical officers. The program for December follows:

SCHOOL FOR MEDICAL OFFICERS, 34TH DIVISION

Dec.	2 p. m.	3 p. m.	7 p. m.	8 p. m.
3	.....	.....	Examination	Examination
4	Examination	Examination		
5	.....	.....	Examination	Work of the Med. Dept. in France, Lieutenant Ramel, French Army
6	Field problem, directed by Captain Milne	Field problem, directed by Captain Milne		
7	Field hospital, internal organization, Major Knott	Care of animals, Lieut.-Colonel McGee, 135th Infantry		
10	.....	.....	Work of the M.D. on the West front, Captain Landale, British Army	Tactical use of infantry, Colonel Mollison, 136th Infantry
11	Field hospitals, their equipment and use, Major Knott			
12	.....	.....	Tactical use of field artillery, Major Oakes, 59th Artillery Brigade	Tactical use of Engineer corps, Colonel Schulz, 109th Engineers
13	Field problem, directed by Captain Milne			
14	Shell shock, Captain Phillips	Work of ophthalmologist in the Army, Captain Covington		
17	.....	.....	Desiderata in treatment, regimental aid station, Major Prudden	Desiderata in treatment at dressing station, Lieutenant Stolz
18	Desiderata in treatment at field hospital, Captain Milne	Desiderata in treatment at base hospital, Major Davis		
19	.....	.....	Tuberculosis: diagnosis and treatment, Major Bullock	Pneumonia in the Army, Captain Duncan
20	Field problem, directed by Captain Milne			
21	Meningitis, Lieutenant D'Alton	Tonsillitis and rheumatism, Major Bigelow		
26	.....	.....	Gas defense, Lieutenant Hickok	Burns, Major Thomas
27	.....	.....	Recent advances in military hygiene, Major Fagan	Cardiovascular disease in Army, Captain Carter
28	Field problem, directed by Captain Milne			
31	Cardiovascular disease in the Army, continued, Captain Carter	Exanthems, Major Pederson		

2. The school for officers of the Dental Corps meets for two hours, five days weekly. Lieut. Mortimer Sanderson, D. C., U. S. Army, is supervising dental surgeon of the division, and Lieut. J. J. Ogden, D. R. C., from Memphis, Tenn., is assistant dental surgeon. Thirty officers of the Dental Reserve Corps constitute the staff, and work in the base hospital and in the infirmaries of the various regiments constituting the division.

3. The school for noncommissioned officers of the Medical Department is just concluding a six weeks' course, which will be continued by the medical officers of each of the various organizations.

4. The school for gas defense. This is conducted by Lieut. Asa L. Hickok, M. R. C., from Meshoppen, Pa., and Lieut. C. N. Austin, S. C., Oak Park, Ill.

A gas house has been established, gas masks are provided, and arrangements are made so that every one in the division will learn the measures of defense necessary to meet this German method of making war.

Eighty-Fourth Division, Camp Zachary Taylor, Louisville, Ky.

DEC. 24, 1917.

CHRISTMAS

Christmas and New Years furloughs at Camp Zachary Taylor did not total more than 2,500 men. Much disappointment was felt when it was announced that only 5 per cent. of the command could be furloughed. Many of the Louisville soldiers found it impossible to get leave to visit their homes on Christmas day. But they found much of good cheer at the camp. The sympathetic public gave liberally toward the Christmas celebration and every man was remembered. Comfort bags, sweaters, socks, tobacco, and many acceptable gifts of all descriptions were given the men.

Among the organizations which have been prominent in arranging for Christmas celebration at the camp are the Camp Service Committee of the Red Cross and the Louisville Committee of National League for Women's Service. These organizations particularly took care of seventeen noncontagious wards at the base hospital in which 950 Christmas presents were distributed.

ADDRESSES

Col. John H. Allen, December 19, addressed the regular December meeting of the Jefferson County Dental Society. Colonel Allen has been very active in having the division equipped with proper dental apparatus, and an ample number of men for taking care of the mouths of every one.

CENSORSHIP

Brigade-General Carleton has placed a ban on indiscriminate writing in the camp. Officers and men may write for publications but their products must be censored by the division intelligence officer. Society editors of papers have been asked not to use their social columns for announcing the departure of officers from the camp or from their homes to other training stations. Only that news which is thought desirable by the division intelligence officer will be given to the press; all other general information is to be withheld.

FOOD CONSERVATION

Use of sugar and lard has been limited at the camp. Organization commanders have been instructed to have coffee prepared in their organizations sweetened before serving to the men, and they will use a maximum of 7 ounces of sugar to each gallon of coffee. In baking not more than 1 pound of sugar and 1 pound of lard will be used with each 100 pounds of flour.

HEALTH OF THE COMMAND

To controvert the false rumors which have been going the rounds regarding the health of the troops, the official records show that since the base hospital was established at the camp 3,684 patients have been treated, and only twenty-eight deaths have occurred, two of which were suicides. Weekly reports from the office of the Surgeon-General at Washington prove that the mortality list and sickness of this command is less than those of other cantonments and camps in the country. From the press, relatives and friends of the soldiers have been warned not to place any credence in the malicious rumors that are being spread, and to assist the government authorities in apprehending those circulating them by reporting the identity of such persons.

Capt. P. J. Stewart, M. R. C., of Paducah, Ky., in charge of the surgical wards at the base hospital, has just been promoted to the rank of major.

It is reported that upward of 3,000 enlisted men from Jefferson and Columbus barracks will be sent to the Lincoln Division before January 1. These men enlisted before December 15, the last day of enlistment according to the last ruling of the provost-general. Fourteen thousand men are included in the outstanding 35 per cent. No definite word has been received as yet regarding their coming. The present strength of the camp is 25,000 men, with accommodations for 44,000 men.

Surgeon-General Gorgas has been expected at Camp Zachary Taylor for the past two weeks. Quite a stir was caused at the base hospital when a telephone call was received for Miss Gallagher, the head nurse, during her temporary absence from the camp. When asked who was talking the reply came back, "General Gorgas."

The Three Hundred and Thirty-Sixth Infantry (composed of Louisville men) and the Three Hundred and Thirty-Fifth Infantry (composed of southern Indiana men) have at last been released from measles quarantine.

ARMY AMBULANCE WORK

All Louisville was shocked to learn of the terrible Louisville and Nashville Railroad wreck, December 20, but thrilled over the prompt assistance rendered the wounded by the ambulance companies from Camp Zachary Taylor. Forty-seven people were killed and as many injured.

Col. John H. Allen, division surgeon, was lecturing before the Louisville Dental Society when he learned of the accident. He immediately communicated with the commanding general of the camp, who gave permission that the ambulance companies be ordered to the scene. At 10:10 p. m., Colonel Allen communicated the order to Major Fletcher, commanding officer of the ambulance companies, to at once report to SS. Mary and Elizabeth Hospital, with its complete medical equipment, including twelve motor ambulances and a personnel of more than fifty men and twenty medical officers.

Within eighteen minutes after the order was received the first ambulance was leaving Camp Zackary Taylor for the scene. The order came after taps, and the officers and men were aroused by messengers who communicated the orders silently through the camp without causing the slightest confusion.

The ambulance companies were from Omaha and Flint, Mich.

The conduct of the soldiers was praised by all who witnessed it, as they rendered valuable aid to the injured. Especially noticeable was the way the injured were handed from the cars through the windows on stretchers without the slightest confusion.

Eighty-Ninth Division, Camp Funston, Fort Riley, Kan.

DEC. 18, 1917.

Lieut.-Col. J. L. Shepard, the division surgeon of the Eighty-Ninth Division, is in the East on a short leave of absence, during which time he intends to visit some of the other cantonments and come back through Washington, D. C. Lieut.-Col. Frank Weed is acting division surgeon during his absence.

The following promotions have occurred in this division since its organization until date: F. W. Weed, major, M. C., to lieutenant-colonel, M. C.; Capts. C. S. McGinnis, G. W. Newell, B. Ffoulkes, J. D. Bartlett and R. H. Meade to be majors; Lieuts. C. K. Barclay, W. L. Hall, O. L. Garlinghouse, L. E. Toney, C. C. Johnson, L. G. Harney, W. T. Cullion, P. K. Sauer, B. C. Dorset, F. M. Manson, J. G. Janney, W. B. Heagerty, C. E. Jenkins, C. Powers, Samuel Adams, G. E. Eggloff, C. M. Fuson, W. C. Kent, A. E. Davenport, D. D. Gill, J. H. Kirkham and W. A. Beckemeyer to be captains.

DISEASE CONDITIONS AMONG TROOPS IN THE UNITED STATES

Extracts from Telegraphic Reports Received in the Office of the Surgeon-General for the Week Ending Dec. 14, 1917

1. Total strength of troops in United States as reported..... 1,001,318
   Annual admission rate per 1,000 (disease only)..... 1,729.7
   Non-effective rate (all divisions) 43
2. National Guard, strength (divisions in United States)..... 367,153
   Annual admission rate per 1,000 all divisions (disease only) 1,757.7
   Non-effective rate all divisions (all causes) 48.6
   Divisions showing admission rate for disease higher than average: Camps Bowie, Kearny, Doniphan, Cody, Wheeler and Shelby.
   Divisions showing non-effective rate all causes higher than average: Camps Bowie, Kearny, Wheeler, Beauregard, Shelby, Cody and Doniphan.
3. National Army, strength (divisions in United States)..... 440,833
   Annual admission rate per 1,000 all divisions (disease only) 1,887.5
   Non-effective rate all divisions (all causes) 40.4
   Divisions showing admission rate for diseases higher than average: Camps Travis, Pike, Zachary Taylor, Funston, Dodge and Dix.
   Divisions showing non-effective rate all causes higher than average: Camps Funston, Travis, Pike, Dodge, Zachary Taylor, Jackson, Lee and Lewis.
4. Venereal Disease:
   Annual admission rate Regulars in United States 69.7
   Annual admission rate National Guard (divisions in U. S.).. 44.6
   Annual admission rate National Army (divisions in U. S.).. 74.3
   National Guard divisions having rate above average: Camps Logan, Wheeler, Sevier, Bowie, Doniphan, Wadsworth, Hancock and Shelby.
   National Army divisions having rate above average: Camps Dix, Upton, Jackson, Lee, Travis and Dodge.
5. Number of cases of pneumonia 611
   Highest number in any one division (36th) 114
   Number of cases of meningitis 86
   Highest number in any one division (81st) 30

6. NEW CASES OF SPECIAL DISEASES REPORTED DURING THE WEEK ENDING DEC. 14, 1917

Division	Pneumonia	Dysentery	Malaria	Venereal	Paratyphoid	Typhoid	Measles	Meningitis	Scarlet fever	Deaths	Strength of Command
27th, Wadsworth	2	...	...	36	..	..	12	..	..	2	31,246
28th, Haneock	1	...	...	28	..	..	2	1	..	1	30,373
29th, McClellan	..	...	...	13	..	..	15	1	..	0	26,915
30th, Sevier	20	...	...	36	..	..	42	6	..	16	27,066
31st, Wheeler	51	...	3	30	..	..	8	1	..	21	22,418
32d, MacArthur	5	...	...	10	..	..	62	..	2	1	27,036
33d, Logan	4	...	1	40	..	..	36	..	..	1	26,957
34th, Cody	42	...	...	11	..	..	116	1	1	7	25,466
35th, Doniphan	22	...	1	31	..	..	237	6	5	12	25,335
36th, Bowie	114	...	...	34	..	..	36	9	..	61	25,971
37th, Sheridan	1	...	...	4	..	..	26	..	..	..	23,948
38th, Shelby	17	...	2	24	..	..	107	..	..	17	27,220
39th, Beauregard	10	...	5	16	..	..	29	3	..	22	23,097
40th, Kearny	5	...	...	12	..	..	330	2	1	3	24,105
76th, Devens	4	...	...	24	..	..	45	..	..	1	27,821
77th, Upton	2	...	...	91	..	..	10	..	..	0	30,712
78th, Dix	5	...	...	87	..	..	9	..	2	1	19,635
79th, Meade	6	...	...	41	..	..	68	4	1	0	33,762
80th, Lee	16	...	...	75	..	..	127	..	..	2	32,771
81st, Jackson	37	...	1	46	..	..	91	30	..	27	18,276
82d, Gordon	9	...	...	23	..	..	74	1	..	2	38,573
83d, Sherman	53	...	...	37	..	..	19	5	..	5	32,596
84th, Taylor	4	1	...	26	..	..	130	5	..	7	22,818
85th, Custer	6	..	...	22	..	..	75	2	..	1	24,124
86th, Grant	6	1	1	5	..	..	37	..	..	1	21,802
87th, Pike	54	1	3	22	..	..	714	2	79	15	29,754
88th, Dodge	5	...	...	34	..	..	36	..	4	3	15,767
89th, Funston	6	...	2	9	..	..	289	6	..	13	26,113
90th, Travis	77	...	...	65	..	..	526	..	..	15	29,640
91st, Lewis	4	...	...	23	..	..	1	1	4	4	36,579

7. ANNUAL RATE PER THOUSAND FOR SPECIAL DISEASES

	Regulars, U. S. Army, in U. S. only, 1916	Regulars in U. S., Week Ending Dec. 14, 1917	National Guard, All Camps, Week Ending Dec. 14, 1917	National Army, All Camps, Week Ending Dec. 14, 1917
Pneumonia	2.59	6.8	41.6	34.6
Dysentery	3.97	2.6	0.0	0.2
Malaria	12.52	1.3	1.7	0.8
Venereal	91.00	69.7	44.6	74.3
Paratyphoid	0.31	0.0	0.0	0.0
Typhoid	0.21	0.3	0.0	0.0
Measles	20.29	58.6	140.8	265.5
Meningitis	0.29	0.0	4.2	6.6
Scarlet fever	0.59	6.5	1.1	10.6

ORDERS TO OFFICERS OF THE MEDICAL CORPS

To Washington, D. C., General Engineering Depot, for duty, and on completion to return to his proper station, Lieut. EDGAR A. BOCOCK.

To Camp Grant, Rockford, Ill., and report in person to the commanding general, for duty, Major GARFIELD L. McKINNEY.

To Washington, D. C., and report to the Surgeon-General of the Army for instruction, Col. ALLEN M. SMITH.

To Camp Sherman, Chillicothe, Ohio, to deliver a course of lectures on camp sanitation, and on completion to return *to his proper station*, Capt. J. GILMORE.

To Washington, D. C., and report to the Surgeon-General of the Army for consultation, and on completion to return *to his proper station*, Major THOMAS D. WOODSON.

To Camp Devens, Ayer, Mass., Camp Upton, L. I., N. Y., Camp Dix, Wrightstown, N. J., to inspect the work of tuberculosis boards, and on completion *to his proper station*, Col. GEORGE K. BUSHNELL.

To Camp Sevier, Greenville, S. C., to report in person to the commanding general, Thirtieth Division, for duty, Lieut. HENRY T. SCHIFFLEY.

To Camp Travis, San Antonio, Texas, Camp Doniphan, Fort Sill, Okla., Camp Bowie, Fort Worth, Texas, Camp Arthur, Waco, Texas, Camp Logan, Houston, Texas, Camp Cody, Deming, N. M., to inspect the laboratory service with special reference to its adequacy for the necessary board of health work in the control of epidemic diseases, and on completion *to his proper station*, Major CLARENCE J. COLE.

To New York City, for temporary duty pertaining to the assembling of the branch of the Division of Finances and Supplies for the Medical Department, and on completion *to return to his proper station*, Col. HENRY D. SNYDER.

To Fort Oglethorpe, and report in person to the commandant, Medical Officers' Training Camp, Camp Greenleaf, for the purpose of organizing and commanding Hospital Train No. 3, Major LAMPHEAR W. WEBB, Jr.

To Fort Benjamin Harrison, Ind., and report in person to the commanding officer of that post for the purpose of commanding Hospital Train No. 2, Major ALEXANDER W. WILLIAMS.

To Fort Benjamin Harrison, Ind., and report in person to the commanding officer of that post for the purpose of commanding Hospital Train No. 3, Major HARRY N. KERNS.

To Fort Benjamin Harrison, Ind., and report in person to the commanding officer of that post for the purpose of commanding Hospital Train No. 4, Major LEOPOLD MITCHELL.

To Camp Sherman, Chillicothe, Ohio, for temporary duty, and on completion *to his proper station*, Major EARL H. BURNS.

To Washington, D. C., and report in person to the Surgeon General of the Army for consultation, and on completion to return *to his proper station*, Lieut.-Col. THOMAS L. RHOADS.

To Camp Doniphan, Fort Sill, Okla., to inspect, and on completion to his proper station, Col. DEANE C. HOWARD.

To Newport News, Va., and report in person to the commanding general, Provisional Division, for duty as divsion surgeon, Lieut.-Col. LARUS D. CARTER.

To Camp MacArthur, Waco, Texas, and report in person to the commanding general, Thirty-Second Division, for duty in connection with the organization and training of the Medical Department, and on completion *to Camp Logan*, Major SAMUEL S. CREIGHTON.

To Hoboken, N. J., and report in person to the commanding general, for duty, Major CHARLES T. KING.

To Richmond, Va., to deliver sixteen lectures on Military Surgery and Medicine, at the Medical College of Virginia, and on completion *to his proper station*, Col. LOUIS J. LA GARDE.

To Camp Devens, Ayer, Mass., and report in person to the commanding general, for duty, Lieut. JOHN S. C. FIELDON, Jr.

To Fort Oglethorpe, and report in person to the commandant, Medical Officers Training Camp, Camp Greenleaf, for duty, Lieut. CLARENCE P. BAXTER.

To Camp Jackson, Columbia, S. C., to make special sanitary inspection, and on completion to his proper station, Lieut.-Col. EDWARD B. VEDDER.

To New York City, Rockefeller Institute, for instruction, and on completion to his proper station, Lieut. EDWARD W. DOUGLAS.

ORDERS TO OFFICERS OF THE MEDICAL RESERVE CORPS

Alabama

To Camp Bowie, Fort Worth, Texas, base hospital, Lieut. CHARLTON S. HARRIS, Birmingham; from Birmingham, Lieut. LEO C. WOODS, Birmingham.

To Camp Devens, Ayer, Mass., base hospital, from Boston, Lieut. HENRY W. GRADY, Birmingham.

To Camp Doniphan, Fort Sill, Okla., base hospital, Lieut. WILLIAM N. BEDDOW, Birmingham.

To Camp Jackson, Columbia, S. C., base hospital, Lieut. LUTHER E. WILSON, Birmingham.

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. HARRY R. COGBURN, Bayou Labatre.

To Fort Oglethorpe for instruction, Lieut. ROBERT F. FENNELL, Guntersville; from University of Pennsylvania, Philadelphia, Lieut. JAMES L. BOWMAN, Union Springs.

To Philadelphia, Pa., for intensive training, Lieut. TOOMBS LAWRENCE, Tuscaloosa.

Arizona

To Camp Pike, Rockford, Ill., to examine the command for mental and nervous diseases, from Ann Arbor, Mich., Capt. HARRY R. CARSON, Phoenix.

Arkansas

To Camp Cody, Deming, N. M., base hospital, from Fort Riley, Lieut. SYLVESTER DOGGETT, Bradford.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. WYLIE R. FELTS, Judsonia.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. ALBERT W. RYE, London.

To Camp Pike, Little Rock, Ark., base hospital, Lieut. ALEXANDER E. HARRIS, Little Rock.

To Fort Oglethorpe, for instruction, from Washington University, St. Louis, Lieut. JAMES W. BUTTS, Helena.

To New York City, New York Post-Graduate Medical School, for instruction in urology and dermatology, from Fort Oglethorpe, Lieut. ARLEY D. CATHEY, Wilson.

California

To Baltimore, Md., Johns Hopkins School, for duty, from Camp Meade, Lieut. PAUL WEGSFORTH, San Diego.

To Camp Bowie, Fort Worth, Texas, to examine the command for mental and nervous diseases, from Camp Lee, Petersburg, Major JAMES R. MOORE, Los Angeles.

To Camp Lewis, American Lake, Washington, D. C., base hospital, Major DUDLEY FULTON, Los Angeles.

To Fort Douglas, Utah, for duty, Lieut. LOUIS N. ANDERSON, Inglewood.

To Fort Oglethorpe, for instruction, from New York City, Lieut. ORAL B. BOLIBAUGH, Los Angeles.

To Fort Riley, for instruction, Major WILLIAM W. ROBLEE, Riverside.

To Hoboken, N. J., base hospital, No. 30, from New York City, Major ALANSON WEEKS, San Francisco.

To Los Angeles, Calif., for orthopedic instruction, Lieut. GUY L. KAY, Wilmington.

To Minneapolis, Minn., University of Minnesota, for duty, Capt. EDWARD C. MOORE, Los Angeles.

To his home and honorably discharged on account of being physically disqualified for active service, from Fort McPherson, Ga., Capt. JOHN R. WALKER, Fresno.

Colorado

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieut. ARTHUR J. HOLMQUIST, Denver.

To Fort Riley, for instruction, Capt. CHARLES E. ELLIOTT, Victor.

To Indianapolis, Ind., for duty, from Fort Sill, Okla., Lieut. WILLIAM W. JONES, Denver.

To San Antonio, Tex., Aviation School, Kelly Field, from Aviation School, Mt. Clemens, Mich., Lieut. JOHN W. THOMPSON, Pueblo.

Connecticut

To Camp Bowie, Fort Worth, Tex., base hospital, from New York City, Capt. OTTO G. WIEDMAN, Hartford.

To Camp Cody, Deming, N. M., base hospital, Lieut. MARK T. SHEEHAN, Wallingford; from Fort Riley, Lieut. JAMES M. MURPHY, Hartford.

To Camp Gordon, Atlanta, Ga., base hospital, Lieut. DANIEL W. PORTER, New Haven.

To Camp Jackson, Columbia, S. C., base hospital, from Fort Oglethorpe, Lieut. RALPH A. RICHARDSON, Bristol.

To Camp Lee, Petersburg, Va., base hospital, from Boston, Lieut. FREDERICK K. HERPEL, Hartford.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. LEVERNE HOLMES, Manchester.

To Camp Meade, Annapolis Junction, Md., to examine the command for tuberculosis, from Walter Reed General Hospital, Lieut. ELLIOTT H. METCALF, Rockville.

To Fort Oglethorpe, for instruction, Lieuts. DWALD E. OLESON, Bridgeport; WINDSOR F. REARDON, Hartford.

To Washington, D. C., for duty, Capt. JOHN H. ROSE, Hartford.

Delaware

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. BRUCE H. BEELER, Wilmington.

District of Columbia

To Camp Devens, Ayer, Mass., base hospital, from Boston, Lieuts. BURGH S. BURNET, EDWARD B. MACON, Washington.

To Camp Meade, base hospital, from Philadelphia, Lieut. JOEL A. TILTON, Washington.

To Camp Travis, Fort Sam Houston, Texas, base hospital, Capt. FREDERICK D. OWSLEY, Washington.

To Fort McPherson, Ga., Base Hospital No. 13, from Harvard Medical School, Lieut. JOHN R. DeVELLING, Washington.

To Fort Oglethorpe, for instruction, from Chicago, Lieut. GRAFTON D. TOWNSHEND, Washington, from New York City; Lieut. JAMES H. ALLEN, for duty, Lieut. JAMES A. CAHILL, JR., Washington.

Florida

To New York City, Base Hospital No. 116, from Fort Oglethorpe, Lieut. JOHN HALLIDAY, Tampa.

Georgia

To Camp Bowie, Fort Worth, Tex., base hospital, from Tallapoosa, Ga., Lieut. LEMUEL J. JOHNS, Tallapoosa.

To Camp Cody, Deming, N. M., base hospital, Lieut. CLAUD T. KEY, Atlanta.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. JOHN M. BEGGS, Paro.

To Camp Jackson, Columbia, S. C., base hospital, Major Stewart R. Roberts, Atlanta; from Atlanta, Ga., Lieut. ALLEN H. BUNCE, Atlanta.

To Camp Joseph E. Johnston, Jacksonville, Fla., base hospital, Lieut. ANDREW L. WEST, Macon.

To Camp Lee, Petersburg, Va., base hospital, from Philadelphia, Lieut. EVERARD A. WILCOX, Augusta.

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. SAMUEL W. HARTWELL, New Sharon.

To Camp Taylor, Louisville, Ky., for duty, from Fort Oglethorpe, Lieut. RICHARD BINION, Sparta.

To Fort Oglethorpe, Hospital Train No. 28, from Fort Oglethorpe, Lieut. ROBERT H. McDONALD, Bullockville; for instruction, Lieut. HUGH K. PHILLIPS, Santee; from New York City, Lieut. HUGH I. BATTEY, Atlanta.

To Lake Charles, La., Signal Aviation School, Gerstner Field, from Aviation Mobilization Camp, Montgomery, Ala., Lieut. EARL K. LAZENBY, Camak.

To Philadelphia, Pa., for intensive training, Lieut. MALCOLM D. CLAYTON, Milledgeville.

Illinois

To Ann Arbor, Mich., for intensive training in his specialty, Lieuts. JAMES K. POLLOCK, Elgin; WALTER C. COOK, Peoria.

To Army Medical School, for duty, Lieut. HARRY T. SWANSON, Chicago.

To Brooklyn, N. Y., First Cavalry Armory, for duty, from New York City, Lieut. MARCUS H. HOBART, Chicago.

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieut. GEORGE W. STEELY, Louisville.

To Camp Doniphan, Fort Sill, Okla., base hospital, Lieut. CLIFFORD WELLS, Chicago.

To Camp Gordon, Atlanta, Ga., base hospital, from Fort Oglethorpe, Capt. JOHN R. HOWE, Peotone.

To Camp Kearny, Linda Vista, Calif., for duty, from Fort Sill, Lieut. THOMAS S. GREEN, Chicago.

To Camp Lee, Petersburg, Va., base hospital, from Boston, Lieut. HARVEY E. WEBB, Chicago.

To Camp Logan, Houston, Texas., base hospital, from Camp Logan, Lieut. WALTER D. HALL, Chicago; for duty, from Camp Logan, Lieut. THOMAS J. RIACH, Kankakee.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. WILLIAM S. BROWN, Cairo.

To Camp Meade, Md., base hospital, from Philadelphia, Lieut. SAMUEL B. CARY, Cairo.

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. HERMAN C. TIETZE, West Salem.

To Fort McHenry, Md., for temporary duty, from Fort Oglethorpe, Lieut. ROBERT S. SALK, Chicago.

To Fort McPherson, Ga., base hospital, from Camp Lee, Lieut. WILSON K. DYER, Kankakee.

To Fort Oglethorpe, for duty, Lieut. LOUIS C. SENDEL, Columbia; for instruction, Lieuts. JOHN G. FROST, PERRE A. STEELE, Chicago; EVANDER D. TAYLOR, E. Moline; from Philadelphia, Lieut. MANDEL A. I. COHEN, Chicago; Hospital Train No. 28, from Fort Oglethorpe, Lieut. ALFRED C. WENDT, Chicago.

To Fort Riley, for instruction, Capt. HALL WHITTAKER, Mound City; Lieuts. THEODORE F. BUTZOW, OSCAR CLEFF, Chicago; ALONZO M. EDWARDS, Marion; from Chicago, Lieut. ORLANDO F. SCOTT, Chicago; Evacuation Hospital No. 1, for duty, from Fort Riley, Lieut. ALEXANDER S. ROCHESTER, Chicago.

To New York City, for instruction in orthopedic surgery, Lieut. IRWIN H. CUTLER, Chicago.

To Philadelphia, Pa., for intensive training, Capt. ROMNEY M. RITCHEY, Elgin.

To San Antonio, Tex., Aviation School, Kelly Field, from Mt. Clemens, Mich., Lieut. HARRY E. BROWN, Peoria.

To Washington, D. C., to report to the Surgeon-General for instruction, and upon completion to Camp Joseph E. Johnston, Jacksonville, Fla., to examine the command for mental and nervous diseases, from Fort Sheridan, Capt. CHARLES RICKSHER, Kankakee; St. Elizabeth's Hospital, from Fort Sheridan, Lieut. WALTER A. FORD, Kankakee.

To his home and honorably discharged on account of being physically disqualified for active service, Fort Oglethorpe, Lieut. GEORGE L. RATHBUN, Galesburg.

To his home and the inactive list, from Fort Riley, Lieut. EDWARD A. CORCORAN, Chicago.

Indiana

To Camp McClellan, Aniston, Ala., for duty, from Fort Oglethorpe, Lieut. JOHN J. CONNELLY, Rockville.

To Camp Meade, base hospital, from Boston, Lieut. HASKETT L. CONNER, Indianapolis.

To Chickamauga Park, Ga., Reorganization Camp, from Columbus, Ohio, Lieut. CLAUDE D. HOLMES, Indianapolis.

To Fort McHenry, Md., for temporary duty, from Allentown, Lieut. CLIFFORD R. HOY, Syracuse.

To Fort McPherson, Ga., Hospital Unit "1," from Fort Oglethorpe, Lieut. CLARENCE L. BOCK, Kokomo.

To Fort Oglethorpe, for instruction, from Fort McPherson, Lieut. JOHN M. LEE, Indianapolis.

To Lake Charles, La., Signal Corps, Aviation School, Gerstner Field, from Montgomery, Ala., Lieut. JULES L. BIERACH, Salem.

To Newport News, Va., for duty, from Fort Snelling, Minn., Lieut. KENNETH L. CRAFT, Indianapolis.

To New York City, for intensive training, Capt. WILLIAM W. SICHELBERGER, Evansville.

To his home and honorably discharged from Fort Oglethorpe, Lieut. BROES S. HORNE, Gas City.

Iowa

To Boston, Mass., Harvard Medical School, for instruction in orthopedic surgery, Capt. EDWIN E. HOBBY, Iowa City.

To Camp Cody, Deming, N. M., base hospital, from Fort Riley, Lieut. GEORGE J. WENZLICK, Iowa City.

To Camp Doniphan, Fort Sill, Okla., to examine the command for mental and nervous diseases, from Camp Doniphan, Capt. THOMAS J. HELDT, Cedar Rapids; for duty, from Fort Riley, Lieut. RAYMOND A. SEILER, Blairstown.

To Camp Joseph E. Johnston, base hospital, from Fort Riley, Lieut. SYDNER D. MAIDEN, Council Bluffs.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieut. WILLIAM H. THOMAS, McGregor.

To Camp Shelby, Hattiesburg, Miss., to examine the command for mental and nervous diseases, from Washington, D. C., Lieut. PERCY B. BATTEY, Independence.

To Dayton, Ohio, Wilbur Wright Station, Aviation Supply Depot, McCook Field, from Montgomery, Ala., Lieut. ROSCOE D. TAYLOR, Spencer.

To Fairfield, Iowa, for duty, from Fort Riley, Lieut. ROY A. McGUIRE, Brighton; Jefferson County Hospital, Lieut. FRANK R. MEHLER, New London.

To Fort Oglethorpe, for instruction, Capt. CHARLES F. SMITH, Des Moines; from Camp Dodge, Capt. FRANCIS LA PISANA, Des Moines; from Philadelphia, Lieuts. THOMAS E. THOMSEN, Charter Oak; THOMAS R. GITTENS, Iowa City.

To Fort Riley, for instruction, Lieut. ELMER P. WEITH, Clinton; Evacuation Hospital No. 1, for duty, from Fort Riley, Lieut. LEO E. SHAFER, Walcott.

To Philadelphia, Pa., for intensive training, Capt. SAMUEL C. LINDSAY, Independence; Lieut. FISHER B. E. MILLER, Cherokee.

To his home and honorably discharged on account of being physically disqualified for active service, from Fort Riley, Lieut. THOMAS W. KING, Maloy.

Kansas

To Camp Cody, Deming, N. M., base hospital, from Fort Riley, Lieut. BEN H. DAY, Hugoton.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. THOMAS S. VENARD, Ness City.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieut. ODUS LISTON, Hudson.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. GEORGE W. POTTS, New Lancaster.

To Fort Leavenworth, Kan., for duty, from Fort Riley, Lieut. MATTHEW H. KEEFER, Kansas City.

To Fort Riley, for duty, from Camp Funston, Lieut. LEONIDAS T. BROWN, Spearville; for instruction, Lieut. BOYD E. EYE, Talmage.

To Newport News, Va., to re-examine troops for tuberculosis, from Camp Meade, Lieut. JACOB H. HALDEMAN, Paola.

Kentucky

To Camp Cody, Deming, N. M., base hospital, Lieut. HARRY E. McCORD, Ludlow.

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieuts. THEODORE SALLEE, Covington; OVERTON H. SAVAGE, Jackson; EUGENE F. BEARD, Lexington.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. ROBERT A. IRVIN, Clay City.

To Fort Oglethorpe, for instruction, Capt. BENJAMIN D. CHOATS, Louisville; Lieuts. MARK E. CALDWELL, ROBERT C. FLEMING, SAMUEL E. STANLEY, Louisville.

To Rockefeller Institute, for instruction, and on completion to Fort Oglethorpe, for instruction, Capt. STEPHEN C. McCOY, Louisville.

To Washington, D. C., for conference with the Surgeon-General, from Bowling Green, Major ARTHUR T. McCORMACK, Bowling Green; from American University, Washington, D. C., Lieut. FLOYD K. FOLEY, Central City.

Louisiana

To Camp Cody, Deming, N. M., base hospital, from Fort Riley, Lieut. HENRY W. A. LEE, Baton Rouge.

To Fort Oglethorpe, for instruction, Lieut. ALBERT C. JACKSON, New Orleans.

To Newport News, Va., to re-examine the troops for tuberculosis, from Camp Meade, Lieut. DELANE S. CALHOUN, Ruston.

Maryland

To Albany, N. Y., for duty, Lieut. DANIEL G. SMITH, Baltimore.

To Boston, Mass., for duty, and on completion to his proper station, Major JAMES BORDLEY, Baltimore.

To Camp Lee, Petersburg, Va., base hospital, from Boston, Lieut. ARTHUR M. BACON, Baltimore.

To Camp Meade, Admiral, Md., base hospital, Lieut. BENJAMIN B. BRUMBAUGH, Denton.

To Camp Sheridan, Montgomery, Ala., base hospital, Capt. HENRY C. REIK, Baltimore.

To Fort Oglethorpe, for instruction, Lieuts. JOSEPH SALAN, HOWARD H. STANSBURY, Baltimore; from duty as a private at Camp Meade, Lieut. MAURICE FELDMAN, Baltimore; from Fort Sam Houston, Lieut. NATHAN WINSLOW, Baltimore; from New York City, Lieut. ALVIN D. LAZENBY.

To New York City, New York Post-Graduate Medical School, for instruction in urology and dermatology, Lieut. AUSTIN H. WOOD, Baltimore.

Maine

To Camp Lee, Petersburg, Va., for duty, from Camp Lee, Lieut. DUDLEY D. KALLOCK, Portland.

To Camp Meade, Md., base hospital, from Boston, Lieut. HAROLD D. ROGERS, Hampden.

To Fort Oglethorpe, for instruction, Lieut. ARTHUR H. PARCHER, Ellsworth.

To Newport News, Va., for duty, from Fort Oglethorpe, Capt. ADELBERT F. WILLIAMS, Phippsburg; Lieut. GILMAN H. CLOUGH, Dexter.

Massachusetts

To Ann Arbor, Mich., for intensive training in his specialty, Lieut. CHARLES E. RODERICK, Raynham Center.

To Boston, Mass., for intensive training in his specialty, from Camp Devens, Capt. DOUGLAS A. THOM, Worcester; from duty as a private at Camp Devens, Lieut. FRANCIS S. CALDICOTT; Harvard Medical School, for instruction in orthopedic surgery, Lieut. ROBERT J. COOK, Boston.

To Brooklyn, N. Y., for duty, from Boston, Capt. DOUGLAS A. THOM, Worcester.

To Camp Devens, Ayer, Mass., base hospital, from Boston, Lieut. OTTIS L. GRAHAM, Boston; from Plattsburg, Lieut. WILLIAM F. RYAN, Lowell.

To Camp Dix, Wrightstown, N. J., Camp Upton, L. I., N. Y., Camp Devens, Ayer, Mass., to inspect and on completion to his proper station, Major ELLIOTT G. BRACKETT, Boston.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Aviation Mobilization Camp, Ala., Capt. CHARLES DUDLEY, Kingston.

To Camp Jackson, Columbia, S. C., base hospital, Lieut. GUY McM. PARKHURST, Cambridge.

To Camp McClellan, Anniston, Ala., to examine the command for nervous and mental diseases, from Camp McClellan, Capt. DONALD R. GILFILLAN, Worcester; from duty, from Fort Oglethorpe, Lieut. LOUIS I. SKIRBALL, Revere.

To Camp Mills, Garden City, L. I., N. Y., for duty, from Boston, Capt. ROBERT F. SOUTHER, Boston.

To Camp Sheridan, Montgomery, Ala., base hospital, Lieut. JAMES A. KEENAN, Roslindale.

To Camp Wadsworth, Spartansburg, S. C., base hospital, from Camp McArthur, Capt. GEORGE D. HENDERSON, Jr., Holyoke.

To Fort Oglethorpe, for instruction, Lieuts. REUBEN L. LEVERTON, Boston; ARTHUR GANLEY, Methuen; JOHN M. CLAFFY, Springfield; JOSEPH J. SKIRBALL, Revere; from Boston, Lieut. JOHN B. WEBSTER, New Bedford; from New York City, Lieut. ALFRED A. FENTON, Norwood.

To New York City, for duty, Lieut. GEORGE D. PACKARD, Jr., Boston; for intensive training, Lieut. APPLETON H. PIERCE, Leominster; for instruction in urology and dermatology, Lieut. EVERETT A. MERRILL, Lynn.

To Philadelphia, New York City, Boston, to standardize courses in orthopedic surgery, and on completion to his proper station, Capt. ALEXANDER S. BEGG, Boston.

Mexico

To Fort Oglethorpe, for instruction, from New York City, Lieut. OTTO R. BROWN, Tampico, Tamaulipas.

Michigan

To Camp Cody, N. M., base hospital, from Ann Arbor, Major FREDERICK H. NEWBERRY, Detroit.

To Camp Custer, Battle Creek, Mich., base hospital, from Camp Custer, Capt. ORTON H. CLARK, Kalamazoo.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. WILLIAM H. MEDDAUGH, Sandcreek.

To Camp McClellan, Anniston, Ala., to examine the command for nervous and mental diseases, from Camp McClellan, Lieut. ARTHUR R. TIMME, Detroit.

To Camp Shelby, Hattiesburg, Miss., to examine the command for mental and nervous diseases, from Camp Shelby, Lieut. RAY S. MORRISH, Flint.

To Fort Oglethorpe, for instruction, from Camp Jackson, Capt. FREDERICK W. BAESLACK, Detroit; from St. Louis, Capt. WILLIAM C. McCUTCHEON, Cassopolis.

To Fort Riley, for instruction, from Camp Custer, Mich., Lieut. SPENCER VAN BARNUM, Coloma; for instruction, Lieut. EDWIN H. CHAUNCEY, St. Albion.

To New York, N. Y., Chicago, Ill., Covington, Ky., for inspection and perfection of roentgen-ray apparatus, and on completion to his proper station, Major JAMES T. CASE, Battle Creek; New York Post-Graduate Medical School, for instruction in urology and dermatology, Lieut. DAUNE W. CRANKSHAW, Lawrence.

To San Antonio, Texas, Aviation School, Kelly Field, for duty, from Mount Clemens, Capt. HOWARD W. STUCH, Allegan.

Minnesota

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. BENJAMIN W. KELLY, Aitkin.

To Camp Sheridan, Montgomery, Ala., to examine the command to eliminate the mentally unfit, from Camp Sheridan, Lieut. WALTER I. LILLIE, Rochester.

To Fort Oglethorpe, for instruction, from St. Louis, Capt. OLIVER E. STEWART, Bricelyn; from Philadelphia, Lieut. ADOLPH M. HANSON, Faribault.

To Philadelphia, Pa., for intensive training, Lieut. EDWARD J. ENGBERG, St. Paul.

To Rochester, Minn., Mayo Clinic, for intensive instruction in anesthesia and surgery, Major EDWARD S. JUDD, Rochester.

To Rockefeller Institute, New York City, for instruction, and on completion to Hoboken, N. J., for temporary duty, from Fort Oglethorpe, Lieut. CLIFFORD C. LECK, Austin.

Mississippi

To Camp Bowie, Fort Worth, Texas, base hospital, Lieut. HUGH C. DONSON, Vicksburg.

To Camp McClellan, Anniston, Ala., base hospital, from Fort Oglethorpe, Lieut. JOHN S. ADAMS, Bay St. Louis.

To Philadelphia, Pa., for intensive training in his specialty, Lieut. THOMAS G. CLEVELAND, Meridian.

To Rochester, N. Y., for duty, from Boston, Lieut. EGBERT H. WESSON, New Albany.

Missouri

To Arcadia, Fla., Signal Corps, Aviation School, Dorr Field, for duty, from Montgomery, Ala., Lieut. FRANCIS X. HARTIGAN, St. Joseph.

To Army Medical School, Washington, D. C., for duty, from Fort Clark, Lieut. CHARLES R. OZIAS, Kansas City.

To Austin, Texas, Aviation Section, Signal Corps, for duty, from Montgomery, Ala., Lieut. JOHN H. TIMBERMAN, Marston.

To Camp Cody, Deming, N. M., base hospital, Lieut. JOHN L. TIERNEY, St. Louis.

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieut. JOHN A. CORN, Amoret.

To Camp Green, Charlotte, N. C., for duty, from Fort Oglethorpe, Lieut. ROBERT R. CUTLER, Berger.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieuts. EDWARD C. WITTWER, Mountain Grove; FRANK HEDGES, Pattonsburg.

To Camp McClellan, Anniston, Ala., to examine the command for nervous and mental diseases, from Camp McClellan, Lieut. CHARLES H. BURDICK, St. Louis.

To Fort Oglethorpe, for instruction, from Boston, Lieut. LEE H. WINEMILLER, Farley.

To Fort Riley, for instruction, Lieuts. EDWIN C. FUNSCH and REUBEN H. WILLIAMS, St. Louis.

To Milwaukee, Wis., Light Horse Squadron Armory, for duty, from Harvard Medical School, Lieut. NOBLE D. McCORMACK, St. Louis.

To New York City, for duty, and on completion to his proper station, Major HANAU W. LOEB, St. Louis; for instruction in orthopedic surgery, from Camp Doniphan, Capt. JOHN P. BEESON, South West City.

To Philadelphia, Chicago and St. Louis, to give instructions in oral and plastic surgery, and to Camp Taylor, Louisville, Ky., and Camp Sherman, Chillicothe, Ohio, for inspection and instruction, and on completion to his proper station, Major VILRAY P. BLAIR, St. Louis; for instruction in orthopedic surgery, Capt. RALPH E. NIODRINGHAUS, St. Louis; for intensive training, Capt. WILLIAM A. EDLER, Lieut. CHARLES H. SHUMAKER, St. Louis.

Montana

To Camp Grant, Rockford, Ill., base hospital, Capt. ALBERT F. LONGEWAY, Great Falls.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, BIGELOW P. BLACKSTONE, Lindsay.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieuts. JOSEPH C. DENNEY, Clydepark; CHARLES B. FLEISCHMANN, Froid; STACY T. NOLAND, Warmsprings.

To Fort Riley, for instruction, Capt. THOMAS A. MacKENZIE, Stacey.

Nebraska

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. IRVIN C. MUNGER, Lincoln.

To Fort Riley, for instruction, Lieut. ROBERT C. PERSON, Omaha.

To Newport News, Va., to reexamine the troops for tuberculosis, from Camp Meade, Md., Lieut. WILLIAM N. ANDERSON, Omaha.

Nevada

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Capt. LAWRENCE R. KNORR, Paradise Valley.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. WILLIAM L. HOWELL, Gardnerville.

New Hampshire

To Camp Wheeler, Macon, Ga., for duty, from Fort Clarke, Major GEORGE V. FISKE, Manchester.

To Fort Oglethorpe, for instruction, Lieut. RALPH S. PERKINS, Exeter.

New Jersey

To Camp Doniphan, Fort Sill, Okla., base hospital, from Fort Oglethorpe, Lieut. FREDERIC H. THORNE, Greystone Park.

To Camp Lee, Petersburg, Va., base hospital, from Boston, Lieut. CHARLES E. BRENN, Camden.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. WILLIAM D. SAYRE, Red Bank.

To Camp Meade, Admiral, Md., for duty, from Fort Myer, Capt. ROBERT E. SOULE, Newark.

To Camp Taylor, Louisville, Ky., for duty, from Fort Oglethorpe, Lieut. JOSEPH BINDER, Jersey City.

To New York City, New York Post-Graduate Medical School, for instruction in urology and dermatology, Lieut. CHARLES RICH, Newark; from Fort Oglethorpe, Lieut. EDWARD GUION, Atlantic City.

New Mexico

To Columbus, for the special examination of tuberculosis, from Camp Wheeler, Lieut. ORIN J. WHITCOMB, Raton.

New York

To Albany, for duty, Major ARTHUR W. ELTING, Capts. LEMUEL W. GORHAM, Albany; CHARLES C. McMULLEN, Schenectady; Lieuts. CLARENCE F. GRAHAM, Albany; JOHN L. EDWARDS, Hudson.

To Army Medical School, Washington, D. C., for duty, from Camp Lee, Lieut. BENJAMIN J. SLATER, Rochester.

To Buffalo, Aviation Section, Signal Corps, as medical member of examining board and recruiting officer, Lieut. EDWARD F. MEISTER, Buffalo.

To Camp Bowie, Fort Worth, Texas, base hospital, Lieut. JOSEPH M. LINETT, Blackwell's Island; base hospital, Lieut. ROBERT L. LEVY, New York; to examine the command for mental and nervous diseases, from Camp Lee, Lieuts. SAMUEL W. HAUSMAN, Ogdensburg; WILLIAM G. DICKINSON, Oneonta.

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieut. WILLIAM J. JACOBS, Carthage; in base hospital, from Boston, Lieut. WILLIAM T. SHIELDS, Troy.

To Camp Devens, Ayer, Mass., base hospital, from Fort Ethan Allen, Vt., Capt. EDWARD G. CLIFTON, New York; from Plattsburg, Capt. WILMARTH S. BUCK, Plattsburg; from Boston, Lieuts. ARTHUR H. NYLEN, Brooklyn; CORNELIUS A. DENEHY, New York.

To Camp Dix, Wrightstown, N. J., for inspection, and on completion to his proper station, Capt. ALEC N. THOMSON, Brooklyn.

To Camp Doniphan, Fort Sill, Okla., to examine the command for mental and nervous diseases, from Camp Mills, Lieut. WARD W. MILLIAS, Rome.

To Camp Gordon, Atlanta, Ga., base hospital, from Fort Oglethorpe, Capt. JOSEPH MUIR, New York.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Capts. CHARLES E. LONG, Buffalo; EDGAR S. BULLIS, Glen Falls; GUSTAVUS C. DARLINGTON, New York.

To Camp Lee, Petersburg, Va., base hospital, from Boston, Lieut. JOHN W. McKEEVER, Newburgh; from Philadelphia, Lieut. CARL C. YOUNT, New York.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. HARRY O. ZAMKIN, New York.

To Camp Meade, Md., base hospital, from Boston, Lieut. EDMUND B. SPAETH, Elmira.

To Camp Pike, Little Rock, Ark., base hospital, from Plattsburg Barracks, Lieut. HAROLD A. BENSON, Kings Park.

To Camp Sevier, Greenville, S. C., for duty, from Fort Riley, Major ANDREW McFARLANE, Albany; base hospital, Capts. EMIL ALTMAN, JOHN A. McAFFERTY, New York.

To Camp Taylor, Louisville, Ky., for duty, from Fort Oglethorpe, Lieut. CONRAD A. RISSBERGER, Albany.

To Camp Upton, L. I., N. Y., base hospital, from Philadelphia, Lieut. GEORGE G. McELVARE, New York.

To Ebertz Field, Lonoke, Ark., for duty, from Montgomery, Ala., Lieut. PERRY L. HELMICK, New York.

To Fort McPherson, Ga., Hospital Unit B, Lieuts. SAMUEL D. BELL, JOHN C. MUTH, Yonkers.

To Fort Oglethorpe, for instruction, from New York City, Capts. KARL OSTERHAUS, Brooklyn; LEO B. MEYER, New York; Lieut. ANDREW W. MAHONEY, New York; for instruction, Lieuts. HAROLD M. WEINBERG, RAPHAEL WOLFE, Brooklyn; ARTHUR C. SMITH, Elmira; EDWARD A. FLYNN, ALEXANDER W. JACOBS, EDMOND H. O'DONNELL, ARTHUR W. URAN, New York City.

To Fort Porter, N. Y., Hospital Unit F., Lieut. FRANCIS J. HALEY, Buffalo; General Hospital No. 4, from Fort Niagara, Lieut. WILLIAM R. SEARS, New York.

To Fort Riley, Kan.; Camp Funston, Fort Riley, Kan.; Medical Officers' Training Camp, Fort Riley, Kan.; Fort Des Moines, Iowa; Camp Dodge, Des Moines, Iowa, base hospitals, and on completion to his proper station, Major PEARCE BAILEY, New York.

To Hoboken, N. J., for duty, from Camp McArthur, Major DANIEL A. SINCLAIR, New York; from Plattsburg Barracks, N. Y., Lieut. ISADORE SEFF, New York.

To Montgomery, Ala., Signal Corps, Aviation School, Taylor Field, for duty, from Montgomery, Ala., Lieut. MAX DOORIN, New York.

To New York City, Post-Graduate Medical School, for instruction in urology and dermatology, Capt. CLAYTON K. HASKELL, Rochester; from Fort Oglethorpe, Lieut. WILLIAM H. GOLDSTEIN, New York; for duty, Lieuts. FREDERICK C. FREED, JOSEPH L. McEVITT, ARTHUR M. REICH, New York; from Camp Jackson, Lieut. JOSEPH S. BALDWIN, Brooklyn; Medical Supply Depot for duty, Lieut. HENRY W. HAYNES, New York.

To Philadelphia, Pa., Aviation Section, Signal Corps, University of Pennsylvania, and on completion *to San Antonio, Texas,* U. S. Aviation School, Kelly Field, from Mineola, Capt. DONALD T. McPHAIL, New York; for temporary duty and on completion *to San Antonio, Texas,* from Forth Ethan Allen, Capt. JOHN D. GULICK, Schenectady; for intensive training in his specialty, Lieut. THOMAS H. RAINES, East View.

To report to Washington, D. C., for temporary duty, and on completion to his proper station, from Army Medical School, Lieut. WALTER G. FOX, Fort Plain; from Fort Myer, Lieut. ABRAHAM L. LOWENTHAL, New York.

To Rockefeller Institute, for instruction, and on completion *to Fort McHenry, Md.,* for temporary duty, from Allentown, Pa., Capt. EDWARD DOWDLE, Oswego; from New York City, Capt. EDWIN G. RAMSDELL, White Plains; Camp Upton, for temporary duty in base hospital, from Fort Oglethorpe, Lieut. HENRY R. KUTIL, New York; for instruction in laboratory work, and on completion to Army Medical School, for duty, Lieut. WALTER S. BENNETT, Glen Falls.

To Washington, D. C., for instruction, Lieut. JAMES B. MURPHY, New York.

To his home and honorably discharged, from Fort Oglethorpe, Lieut. FRANK P. IVES, New York.

North Carolina

To Fort Oglethorpe, for instruction, from duty as a private at Camp Jackson, Lieut. HOLMAN BERNARD, Pinnacle.

To Philadelphia and Pittsburgh, Pa.; Cleveland, Ohio; Detroit and Battle Creek, Mich.; Chicago and Rockford, Ill.; Minneapolis, Minn.; Des Moines, Iowa; Omaha, Neb.; Fort Riley, Kan.; Kansas City and St. Louis, Mo.; Indianapolis, Ind.; Louisville, Ky.; Cincinnati and Chillicothe, Ohio, to examine applicants for the A. S., S. C., and on completion to his proper station, from Washington, D. C., Major R. LEWIS, Raleigh.

To his home and honorably discharged, from Camp Wadsworth, Lieut. MARVIN L. SMOOT, Fayettesville.

Ohio

To Camp Cody, Deming, N. M., base hospital, Lieuts. WILLIAM F. MILLHON, Columbus; VIRGIL J. FRUTH, Fostoria.

To Camp Doniphan, Fort Sill, Okla., to examine the command for mental and nervous diseases, from Camp Mills, Lieut. JOHN C. GEORGE, Dayton.

To Camp Kearney, Linda Vista, Calif., for duty, from Camp Bowie, Lieut. VICTOR R. SMALL, Columbus.

To Camp Meade, Md., base hospital, from Philadelphia, Lieut. ALLEN N. WISELEY, Ada.

To Fort Oglethorpe, for instruction, Lieut. HARRY E. WOODBURY, Akron.

To New York City, Post-Graduate Medical School, for instruction in urology and dermatology, Lieut. LAWRENCE D. MILLER, Toledo.

To Philadelphia, Pa., for training in his specialty, from Camp Greene, Lieut. HOWARD H. DAVIS, Cleveland.

To Rockefeller Institute, N. Y., for instruction, and on completion *to Camp Upton,* L. I., N. Y., base hospital, from Fort Oglethorpe, Lieut. CARROLL H. SKEEN, Senecaville.

To his home and honorably discharged, from Camp Taylor, Capt. ELIJAH W. TIDD, Stockdale.

Oklahoma

To Camp Custer, Battle Creek, Mich., for duty, from Fort Riley, Lieuts. JOHN V. ATHEY, Bartlesville; FRANK A. FANNIN, Stigler.

To Fort Oglethorpe, for instruction, Capt. JOHN C. MAHR, Oklahoma City; from Philadelphia, Lieut. DAVY L. GARRETT, Altus.

To Fort Riley, for instruction, Lieuts. JOSEPH H. STOPLER, Muskogee; EARL L. YEAKEL, Norman.

To Lake Charles, La., Signal Corps, Aviation School, Gerstner Field, from Montgomery, Ala., Lieut. JAMES R. BOST, Cashion.

To his home and honorably discharged, on account of being physically disqualified for active service, from Fort Oglethorpe, Lieut. LOUIS C. KUYRKENDALL, McAlester.

Pennsylvania

To Camp Bowie, Fort Worth, Texas, base hospital, Lieut. FRED D. REYNOLDS, Pittsburgh.

To Camp Cody, Deming, N. M., base hospital, from Fort Oglethorpe, Lieut. ANDREW J. W. HANDWORK, Altoona.

To Camp Devens, Ayer, Mass., base hospital, from Camp Devens, Capt. DANIEL M. HOYT, Philadelphia; from Boston, Lieuts. HENRY C. DOOLING, Norwood Station; ALBERT W. GREENWELL, Philadelphia.

To Camp Doniphan, Fort Sill, Okla., base hospital, from Chickamauga Park, Lieut. JOSEPH D. ARONSON, Philadelphia.

To Camp Grant, Rockford, Ill., base hospital, from Camp Grant, Lieut. ALLEN H. MOORE, Philadelphia.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieut. ALBON E. FICHTNER, Conemaugh.

To Camp Logan, Houston, Texas, for duty, from Fort Clarke, Texas, Capt. CAREY J. VAUX, Pittsburgh.

To Camp Meade, Md., for duty, Capt. WILLIAM F. McLAUGHLIN, Philadelphia; base hospital, from Philadelphia, Lieut. LOUIS H. MAYER, Johnstown.

To Camp Pike, Little Rock, Ark., base hospital, from Army Medical School, Lieut. SOLOMON F. HOGE, Philadelphia.

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. JESSE B. HOWE, Erie.

To Camp Wheeler, Macon, Ga., base hospital, from Camp Wheeler, Lieut. JOHN H. STEARNS, Delaware Water Gap.

To Fort McHenry, Md., for temporary duty, from Allentown, Pa., Lieut. ALEXANDER D. FERGUSON, Eddystone.

To Fort Oglethorpe, for instruction, Lieuts. SAMUEL A. KAMERER, Ellsworth; FRANCIS M. S. SCHAM, Johnstown; JOHN D. DONNELEY, Philadelphia; from Boston, Lieut. SUMNER C. SIMPSON, Pittsburgh; from New York City, Lieut. PHILIP J. LUKENS, Jr., Philadelphia; from Philadelphia, Lieuts. GEORGE H. FAGGERT, FRANK G. MURPHY, Philadelphia; Hospital Train No. 27, from Fort Oglethorpe, Lieut. HOWARD C. HEILMAN, Pittsburgh.

To Newport News, Va., to reexamine the troops for tuberculosis, from Camp Meade, Lieut. WILLIAM H. HERR, Lancaster.

To New York City, for intensive training, Lieut. DAVID B. HAWKINS, Curwensville; Post-Graduate Medical School, for instruction in urology and dermatology, Lieut. DAVID P. McCUNE, Jr., McKeesport.

To Philadelphia, for duty, Major CHARLES F. HASSAN, Philadelphia; for instruction in traumatic surgery and fractures, Major EDWARD MARTIN, Philadelphia; for intensive training, Capt. WILLIAM W. RICHARDSON, Mercer.

To Pittsburgh, Hospital Unit "L," Allegheny General Hospital, from Camp Hancock, Major WALTER A. DEARTH, Pittsburgh.

To Takoma Park, D. C., for duty, from New York City, Lieut. CHARLES E. YOHO, Pittsburgh.

To Washington, D. C., for a conference and on completion to his proper station, from Evans Institute, Philadelphia, Capt. CARLTON N. RUSSELL, Philadelphia, Camp American University, for duty, from Fort Oglethorpe, Lieut. WILLIAM J. HARRISON, Philadelphia.

To his home and honorably discharged, from Camp Bowie, Capt. JOSIAH T. BUNTING, Philadelphia; from Camp Green, Lieut. WILLIAM F. McANALLY, Philadelphia; from Camp Jackson, Lieut. CLARENCE W. LURTING, Pittsburgh.

Rhode Island

To Camp Kearney, Linda Vista, Calif., base hospital, from Camp Kearny, Lieut. JOHN P. JONES, Wakefield.

South Carolina

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. JOHN M. BEARDEN, Lawrence.

To Fort McHenry, Md., for temporary duty, from Allentown, Pa., Lieut. JOHN R. BOLINE, Columbia.

To Fort Oglethorpe, for instruction, Lieut. LEWIS M. GRIFFITH, Columbia.

Honorably discharged on account of being physically disqualified for active service, Lieut. ARTHUR D. MORGAN, North.

South Dakota

To his home and honorably discharged on account of being physically disqualified for active service, Lieut. ALBERT S. RIDER, Flandreau.

Tennessee

To Austin, Texas, for duty, from Everman, Texas, Lieut. FLEMING J. O'CONNER, Jackson.

To Camp Bowie, Fort Worth, Texas, to examine the command for mental and nervous diseases, from Camp Lee, Lieut. HOWARD M. FRANCISCO, Nashville.

To Camp Sherman, Chillicothe, Ohio, for duty, from Fort Oglethorpe, Lieut. JOHN S. MILLER, Callierville.

To Fort Barrancas, Fla., for duty, from Camp Shelby, Lieut. DANIEL B. CLIFFE, Franklin.

To Fort Oglethorpe, for instruction, Lieuts. ELLIS LeR. WILKINS, Dyersburg; ROBERT E. SULLIVAN, Nashville; Hospital Train No. 22, from Fort Oglethorpe, Lieut. EMMETT E. BROWN, Nashville.

Texas

To Army Medical School, for duty, from Fort Clark, Lieut. LEVY S. JOHNSON, Richmond.

To Camp Lewis, American Lake, Wash., for duty, from Camp McArthur, Lieut. JAMES J. JOHNSON, Sulphur Springs.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Capt. JESSE L. WOMACK, Lolita.

To Fort Oglethorpe, Evacuation Hospital No. 6, from Fort Oglethorpe, Lieut. BENJAMIN F. LARGENT, McKinney; for instruction, Lieuts. NEWELL W. ATKINSON, Alice; EDWARD W. TISDALE, Clyde; JAMES A. SHACKELFORD, Thurber; from Boston, Lieut. ROBERT L. HOWELL, Snyder.

To Indianapolis, for duty, and on completion to return to his proper station, Major JOHN B. McLEAN, Fort Worth.

To Rockefeller Institute, for instruction and on completion to Camp Upton, L. I., N. Y., base hospital, from Fort Oglethorpe, Lieut. THOMAS R. SEALY, Santa Anna.

To South San Antonio, Texas, Kelly Field, in connection with the Physical Examining Unit, Capt. TARLETON F. MOORE, Galveston.

To Washington, D. C., Camp American University, from Fort Oglethorpe, Lieut. DAVID C. WILLIAMS, Post.

Utah

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Capt. CHAUNCEY M. BENEDICT, Salt Lake City.

Vermont

To Fort Oglethorpe, for instruction, Lieut. GEORGE C. RUBLEE, Hardwick.

To Philadelphia, for temporary duty and on completion to San Antonio, Texas, from Fort Ethan Allen, Lieut. ARTHUR L. LARNER, Burlington.

Virginia

To Camp Devens, Ayer, Mass., for duty, from Fort Sill, Major CHARLES A. BROWN, Dillwyn; base hospital, from Boston, Lieut. PERCY E. DUGGINS, Norfolk.

To Camp Jackson, Columbia, S. C., base hospital, from Fort Oglethorpe, Lieut. QUINTUS H. BARNEY, Richmond.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieut. WILLIAM E. BROWN, Catawaba Sanatorium.

To Camp Pike, Little Rock, Ark., base hospital, from Philadelphia, Capt. HOWARD FLETCHER, Fairfax.

To Camp Wadsworth, Spartanburg, S. C., base hospital, from Fort Oglethorpe, Lieut. MAURICE A. SELINGER, City Point.

To Fort Oglethorpe, for instruction, Lieuts. FRANK W. LEWIS, Merattica; CHARLES E. LLEWELLYN, Richmond.

To Newport News, Va., for duty, Capt. SAMUEL A. RIDDICK, Smithfield.

To Rockefeller Institute, for instruction, and on completion to Takoma Park, D. C., for temporary duty, from Fort Oglethorpe, WILSON H. DRIVER, Norfolk.

Washington

To Camp Lewis, American Lake, Wash., for duty, from Camp Bowie, Capt. ISAAC W. POWELL, Bellingham.

Honorably discharged on account of holding commission in the National Guard, Capt. JOHN B. KINNE, Aberdeen.

West Virginia

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. HARVEY C. POWELL, Morgantown.

To Fort McHenry, Md., for temporary duty, from Allentown, Pa., Lieut. MARTIN L. SOWERS, Bluefield.

To Fort Oglethorpe, for instruction, from Fort Ethan Allen, Lieut. HARRY D. LAW, Conings.

To New York City, for intensive training in his specialty, Lieut. ROSS DODSON, Spencer.

Wisconsin

To Arcadia, Fla., Signal Corps, Aviation School, Carlstrom Field, from Montgomery, Ala., Lieut. RAYMOND A. HEBRON, Cataract.

To Camp Cody, Deming, N. M., base hospital, from Fort Riley, Lieuts. EZRA J. MITCHELL, Brodhead; CLARK O. DECKER, Crandon; HARRY E. GILLETTE, Packwaukee; HARRY C. McCARTHY, Richland Center.

To Camp Devens, Ayer, Mass., to examine the command in mental and nervous diseases, from New York City, Lieut. CHARLES C. ROWLEY, Winnebago.

To Camp Hancock, Augusta, Ga., motor mechanic regiments, from Montgomery, Ala., Lieuts. ALBERT H. KULIG, Dodge; CHARLES M. PEARSON, Ogema; EDWARD P. EVANS, South Milwaukee.

To Camp McClellan, Anniston, Ala., for duty, from Fort Oglethorpe, Lieut. WILLIAM E. ALLEN, Sun Prairie.

To Dayton, Ohio, Wilbur Wright Station, Aviation General Supply Depot, McCook Field, from Montgomery, Ala., Lieut. ATHOL H. WEDGE, Waupun.

To Fort Leavenworth, Kan., for duty, from Fort Riley, Lieut. FRANKLIN M. HAWLEY, Bayfield.

To Fort Riley, base hospital, Lieut. ABRAHAM B. SCHWARTZ, Milwaukee.

To Fort Slocum, N. Y., for duty, from Neurological Institute, N. Y., Lieut. SMILEY BLANTON, Madison.

To Great Lakes, Ill., to observe construction, organization, equipment and administration of the hospital at the Naval Training Station, and on completion to return to his proper station, Major NELSON M. BLACK, Milwaukee.

To Philadelphia, for instruction in orthopedic surgery, Lieut. BERNARD O. BENDIXEN, Kewaskum.

Honorably discharged on account of being physically disqualified, Capt. GUSTAF R. EGELAND, Sturgeon Bay.

CORRECTION

Under "Orders to Officers of the Medical Reserve Corps" in the issue of November 3:

Lieut. JOHN D. MILLER, of Little Falls, N. Y., instead of Cincinnati, O., was ordered *to Camp Grant*, Rockford, Ill., for duty with the 35th Engineers.

Issue of December 15: Lieut. HERBERT L. WILLIAMS, Auburn, Me., instead of Bartonville, Ill., was ordered *to Camp Gordon*, Atlanta, from Fort Oglethorpe.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST; SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

FLORIDA

Addition to Hospital.—The addition to the Lee County Hospital, Fort Myers, is practically completed, giving the institution six new rooms, four of which have already been furnished.

New Officers.—Escambia County Medical Society, at Pensacola, December 11: president, Dr. L. de Blocker, Pensacola; vice president, Dr. William D. Nobles; secretary, Dr. Fritz A. Brink, and treasurer, Dr. Walter C. Payne, all of Pensacola.——Hillsborough County Medical Society, at Tampa, December 4: president, Dr. Reuel A. Fly; vice president, Dr. Leland F. Carlton; secretary, Dr. Gilbert H. Hodgson, and treasurer, Dr. Jesse J. Saxton, all of Tampa.——Du Val County Medical Association, at Jacksonville, December 4: president, Dr. Frederick J. Waas; vice president, Dr. William E. Ross, and secretary-treasurer, Dr. Elmo D. French, all of Jacksonville.

GEORGIA

New Sanatorium Building.—Advertisement has been made by the board of trustees of the Georgia State Sanatorium, Milledgeville, for proposals for the construction of a sanatorium building.

New General Hospital.—The Military Hospital at Fort McPherson, Atlanta, has been changed from a base hospital to a general hospital. The new hospital will remain in command of Col. Thomas S. Bratton.

New Officers.—Randolph County Medical Society at Cuthbert, December 11: president, Dr. John L. Shephard, Carnegie; vice president, Dr. Thomas F. Harper, Coleman, and secretary-treasurer, Dr. George Y. Moore, Cuthbert.

Public Health Service Furnishes Health Officers.—P. A. Surg. Charles L. Williams, U. S. P. H. S., is to become health officer of Macon. Dr. Charles Wardell Stiles, U. S. P. H. S., has arrived in Augusta to take charge of the health situation in the zone contiguous to Camp Hancock.

Personal.—Dr. Craig Barrow, Savannah, has been appointed chief surgeon of the Central Georgia Railroad and Ocean Steamship Company, succeeding Dr. William W. Owens, deceased. Dr. Barrow has appointed Dr. Lawrence Lee as assistant surgeon.——Dr. Roger C. Swint has been appointed clinical director of the State Sanatorium, Milledgeville, succeeding Dr. Edward M. Green, resigned to accept the superintendency of the Pennsylvania State Sanatorium.

ILLINOIS

Chicago

Fire in Fraternity House.—Medical students were routed from bed, December 17, when the Phi Rho Sigma fraternity house of Northwestern University caught fire. The damage to the building was estimated at $500.

Dispensary Moves.—The Army Dispensary formerly in the Federal Building was moved, December 22, to its new quarters at 820 Michigan Boulevard Building. Major Samuel C. Stanton, M. R. C., is in command and has as his assistants, Capt. Albert H. Rober, M. R. C., and Lieuts. Claude H. Ogden, M. R. C., Roy R. Haley, M. R. C., and Charles B. Gibson, M. R. C.

Society of Internal Medicine.—At the twentieth regular meeting of the Chicago Society of Internal Medicine, December 17, the program included papers by Dr. Lewis J. Pollock and William Cluney on "Vital Stains and Central Nervous System"; by Dr. Arthur F. Beifeld on "An Etiologic Phase of Pernicious Anemia," and by Drs. Rollin T. Woodyatt and William D. Sansum, on "Treatment of Mercuric Chlorid Poisoning: An Experimental Study."

INDIANA

Physicians Win Suit.—In the damage suit for $25,000 brought against Drs. James H. Fargher and Orlando L. Sutherland, La Porte, in which the defendants were charged with failing properly to set a fracture of the ribs, a verdict was rendered in the St. Joseph circuit court, December 14, in favor of the physicians.

Personal.—Dr. Sterling P. Hoffmann, Bluffton, is ill with smallpox.——Dr. J. Rilus Eastman, Indianapolis, spoke before the Madison County Medical Society, November 27, on "War Surgery."——Dr. Rose Alexander Bowers, Michigan City, has been appointed a member of the staff of the Mayo Clinic, Rochester, Minn.——Dr. Edward J. McOscar, Fort Wayne, was awarded the first prize for the best paper read at the annual meeting of the Pennsylvania Railway Surgeons' Association.

Smallpox.—The state board of health will, it is expected, soon take drastic action to check the spread of smallpox in the state. The board of health of Indianapolis has already initiated such action, and requires that all children be vaccinated.——During November, ninety cases of smallpox were reported in Indianapolis, and during the first ten days in December, sixty-five additional cases were reported.——The health authorities of Fort Wayne believe that they have the smallpox epidemic under control.——A number of cases of smallpox are said to have developed at Grabill.

IOWA

Field Hospital Unit Mustered.—The field hospital unit was mustered in at Iowa City, December 8, under command of Major Francis L. Love, Iowa City.

Personal.—Dr. Frank W. Lee, Riceville, fell to the bottom of his silo chute, December 10, sustaining severe injuries.——Capt. Daniel J. McCarthy, Davenport, is in charge of the second Red Cross Hospital, opened at Jassy, Roumania, December 4.

New Officers.—Dubuque County Medical Society, at its annual meeting, December 11, in Dubuque, elected the following officers: president, Dr. Joseph H. Schrup; vice presidents, Drs. Frank W. Meyers, Dubuque, and Hierstein, Dyersville; secretary, Dr. Clarence E. Lynn, and treasurer, Dr. Henry M. Pahlas, Dubuque.

Hospital Items.—At a meeting of the authorities of Grinnell College with the Women's Club of the city, the plans for a detention hospital for contagious diseases were endorsed, and a committee was appointed to secure the funds for the erection.——Miss Lottie Heywood has been placed temporarily in charge of the Eleanor Moore Hospital, Boone.——Two wards and a number of private rooms have been added to the Anamosa Hospital, which now has accommodation for twenty patients.

MARYLAND

Personal.—Capt. Clement A. Penrose, Baltimore, has returned from a four months' visit to London, Paris, and the trenches in France and Flanders, commissioned to make an investigation of sanitary conditions.——Dr. Archibald C. Harrison, who holds a commission as major in the University of Maryland Hospital Unit, has returned to his home in Baltimore, after spending several week in Virginia, recuperating from a serious operation.

Memorial to Dr. Chambers.—In the main operating room at the Mercy Hospital, an impressive bronze tablet of the late Dr. John W. Chambers has been erected as a memorial to him by the Alumni Association of the College of Physicians and Surgeons. The tablet is a medallion portrait of Dr. Chambers, and is the work of Maxwell Miller, the local

sculptor. There were no formal exercises at the unveiling of the memorial, which was private, and in the presence of the members of Dr. Chambers' family, with Sisters of Mercy and the resident staff of the hospital.

MASSACHUSETTS

Whooping Cough Hospital.—What is said to be the first hospital in the United States devoted to pertussis was opened, December 7, in one of the buildings of the west department of the City Hospital.

Federal Hospital on Long Island.—It is announced that Long Island, Boston Harbor, will be taken by the federal government for hospital purposes. The mayor of Boston will use the $1,300,000 realized by the sale to build 500 cottages for the sick and poor now on the island.

Work of Women on Battlefields.—Dr. Rosalie Slaughter Morton, New York, chairman of the war service committee of the Woman's National Medical Association, was a guest of honor at a dinner of the Women's National City Club, Boston, December 5. Dr. Morton described the work of women in the battlefields and hospitals of France, Belgium and Serbia.

Addition to Hospital.—The Municipal Council of Haverhill has appropriated $70,000 for the erection and equipment of an addition to the Glen Gale Hospital. The plans provide for a two-story brick structure to be erected in the rear of the present hospital, increasing its capacity from fifty to 100 patients. It is also proposed to establish a general medical dispensary and outpatient department at the hospital.

Personal.—Dr. Wallace C. Keith, Brockton, was installed as grand master of the Grand Council of Masons at the annual meeting in Boston, December 10.——Dr. Halbert C. Hubbard, Worcester, has been appointed assistant physician to the State Sanatorium, Rutland.——Drs. M. Victor Safford, Honore Van De Velde and Benjamin A. Graves, Boston, were deputized by the mayor to go to Halifax, N. S., and give such aid as they could to the people of the afflicted city.

MONTANA

Smallpox.—In Butte and Silver Bow counties there are said to be 150 cases of smallpox, many of which are of the most malignant type, and compulsory vaccination is suggested by the authorities.

Personal.—Dr. Arthur Morrow, Kalispell, has been named as physician of Flathead County and health officer of Kalispell.—— Dr. Max W. Barbour has been appointed health officer of Helena, succeeding Dr. Ellis A. Johnston, resigned.

NEW JERSEY

Personal.—Dr. John J. Broderick has been appointed surgeon of the police department of Jersey City.——Lieut. James H. Haines, M. R. C., Haddon Heights, is reported to be seriously ill with measles at Camp Pike.

Loyalty Meeting.—A patriotic meeting of the physicians of Trenton and their families was held, December 13, at which Dr. William W. Keen, Philadelphia, and Major Charles A. E. Codman, M. R. C., U. S. Army, Philadelphia, delivered addresses, and Major Henry D. Jump, Philadelphia, presented moving pictures of war conditions abroad and of cantonments in this country.

Clinic for Syphilis.—In compliance with a resolution adopted recently by the Morris County Medical Society that, "If possible, at least three hospitals in the county establish a clinic for the treatment of syphilis or specific blood disorders," the board of managers of the New Jersey State Hospital at Morris Plains at its recent annual meeting authorized the establishment of such a clinic at this hospital. Through the liberality of private concerns, the necessary drugs are to be provided without expense to the hospital or state.

NEW YORK

Offers Estate for Convalescent Home.—Froh Heim Farms, the 5,000-acre country estate of the late Grant B. Schley, New York, has been offered by his heirs to the government for a home for convalescent soldiers.

Vassar to Train Nurses.—A committee of the trustees of Vassar College has been appointed to work out plans for a school for the intensive training of registered nurses. In cooperation with the committee on nursing of the Council on National Defense it is also planned to hold a summer conference of Red Cross home service workers, and to establish a normal institute under the auspices of the American Red Cross.

Medical Military Aid.—The American Medical Military Aid Association was incorporated in New York, December 15. The purpose of the association is "To give voluntary medical aid and voluntary assistance to the dependent families of men enlisted in the United States Army and Navy." The directors are Drs. John Ernest Gignoux, Wolff Freudenthal, Mary L. E. Daly McLean, Freeman F. Wood, Isadore L. Hill and Robert Emery Brennan, Mrs. Florence Eno Graves and Mr. Willis G. Nash, all of New York.

New York City

The Flint Estate.—The estate of the late Dr. Austin Flint, who died, Sept. 21, 1915, has been appraised at $144,518 gross. It is to be divided between his two sons and a grandson.

Tubercuosis Hospial Admission Bureau Moves.—The Hospital Admission Bureau, which is maintained jointly by the department of health and the Department of Public Charities, has removed from First Avenue near Twenty-Fifth Street to 145 Worth Street, where it will be more easily accessible and where larger quarters have been secured.

Pneumonia Continues to Increase.—While New York is not suffering from an epidemic of pneumonia, the disease has been unusually prevalent not only in the city but throughout the state, and both the city and state health departments have been keeping before the public the fact that pneumonia is an infectious and communicable disease and one that is to a large extent avoidable if proper precautions are taken. For the week ended December 14 there were, out of 1,443 fatalities, 263 due to pneumonia; for the preceding week, out of 1,417 deaths, 220 were caused by pneumonia. The average number of deaths from pneumonia for this time of year in this city is about 200. While there is usually an increase in the number of deaths from respiratory diseases as the winter progresses, this year the increase began earlier and has continued at a much higher rate than usual.

Personal.—Dr. Thomas Darlington, formerly health commissioner in New York, has been engaged permanently as sanitary commissioner of the American International Ship Building Co.——Dr. Walter J. O'Connell of the Buschwich Hospital was seriously injured in a collision between an ambulance of the hospital and a street car, December 10.——As a result of a competitive examination for the position of chief medical examiner of New York, Dr. Otto H. Schultze, pathologist to the district attorney, and Drs. Charles Norris and Douglas Symmers of the pathologic laboratories of the Bellevue Hospital have qualified for the position. The new examiner takes the place formerly held by the coroner.—— Drs. Burr B. Mosher, John Osborn Polak, Sylvester J. McNamara, Jaques C. Rushmore, Henry M. Mills and Henry M. Moses, all of Brooklyn, has been appointed councilors of the Long Island College Hospital Alumni Association.

OHIO

Smallpox in Toledo.—Smallpox is reported to be unusually prevalent in Toledo. It is stated that there are approximately 20,000 unvaccinated children in public schools.

Academy Election.—At the annual meeting of the Muskingum County Academy of Medicine, held in Zanesville, December 12, Dr. Leroy F. Long was elected president; Dr. William F. Sealover, vice president, and Dr. Oren I. Dusthimer, secretary-treasurer.

Personal.—Dr. Edward Herbst, Columbus, who is about to retire as a member of the board of education, took the highest rank in the recent civil service examination for city physician.——Dr. Rush R. Richison, Yellow Springs, assumed his new duties as superintendent of the District Tuberculosis Hospital, Springfield, December 21.——Dr. Edward J. Schwartz, for fifteen years health officer of Salem, has resigned to accept the position of director of communicable diseases in the state department of health.

PENNSYLVANIA

Personal.—Dr. W. Edgar Holland, Fayetteville, has been elected physician to the Franklin County Home, succeeding Dr. John K. Gordon, Chambersburg.——Dr. Mary Janet Alexander, Chester, has resigned to take up work as a medical missionary in India.——Dr. Jesse Cope Green, a well known dentist of West Chester celebrated his 100th birthday anniversary, December 13.——Dr. Oliver C. Heffner, Pottstown, received severe burns of the face and hands while pouring an antifreezing solution into his automobile.——Dr.

Edward L. Davis, Berwick, has been appointed coroner for Columbia County, to succeed Dr. William H. Hoffa, deceased.

Philadelphia

Personal.—Lieut. Hugh Cotter Boyle, formerly of the British Ambulance Corps No. 17, with the rank of regimental surgeon, and later transferred to the Second Durham Infantry, was severely wounded in action in France, December 7. Dr. Boyle served for a year as an intern in the Samaritan Hospital, and practiced in this city until last May.——Dr. Samuel G. Dixon was reelected, for the twenty-second consecutive time, president of the Academy of Natural Science at the annual meeting, December 18.

TEXAS

Free Clinic.—The health department of Amarillo has established a free clinic at the Amarillo Hospital, which will be held for two hours each week for the benefit of indigent patients.

Hospital for Tuberculous Negroes.—The health department of Dallas has asked the county commissioners' court to appropriate a sum of money for the construction of a hospital to be used for the treatment of negroes suffering from tuberculosis.

North Texas Physicians Meet.—At the seventy-sixth semiannual meeting of the North Texas Medical Association, held in Dallas, December 11 and 12, the following officers were elected: president, Dr. H. Leslie Moore, Dallas; vice president, Dr. Sidney J. Wilson, Fort Worth; secretary, Dr. David L. Bettison, Dallas, and treasurer, Dr. Martin L. Wilbanks, Greenville. A committee was appointed to petition congressmen and senators to eliminate that portion of Section 2120, of the Emergency War Revenue Act, which provides a professional tax of an additional 8 per cent.

State Health Board Notes.—A meeting of the state board of health was held at Laredo, December 10, to discuss the work of the present year, and outline plans for the coming year, and to consider the Mexican border quarantine service and other matters of public importance.——Dr. David E. Rouse, epidemiologist to the Ohio State Board of Health, and director of Red Cross Unit No. 12, Chillicothe, Ohio, has been appointed field director by the state board of health. ——Dr. Albert H. Braden, Beaumont, has been appointed a field director by the state board of health, and will have charge of the work in McLellan County.

WASHINGTON

New Health Officer, Chemist and Bacteriologist for Tacoma.—Dr. Hilbrand J. Hards has been appointed health officer of Tacoma, succeeding Dr. Jonathan E. Henry, resigned, to take effect, January 18.

New County Officers.—At the meeting of the Whatcom County Medical Association, held in Bellingham, December 10, the following officers were elected: president, Dr. Edward W. Stimpson; vice presidents, Drs. Carl C. Hills, Albert M. Dawson and Newton W. Wear; secretary, Dr. Orville E. Beebe, and treasurer, Dr. Frank J. Van Kirk, all of Bellingham.

GENERAL

Rutland Railway Surgeons Elect Officers.—At the annual meeting of the Rutland Railway Surgeons' Association, held in Burlington, Vt., December 13, the following officers were elected: president, Dr. James M. Hackett, Champlain, N. Y.; vice president, Dr. Joel B. Woodhull, North Bennington, Vt., and secretary-treasurer, Dr. Stanton S. Eddy, Middlebury, Vt.

Bequests and Donations.—The following bequests and and donations have recently been announced:

Building fund of the People's Hospital, New York, a donation of $5,000 from Louis Koenberg, and $3,000, the proceeds of a theatrical benefit.

King Edward's Hospital Fund, London, a donation of $175,000 from Viscount Astor.

Provident Hospital, a contribution of $1,000 in cash by negroes of the city.

New Officers for Southwestern Association.—At the fourth annual meeting of the Southwestern Medical and Surgical Association, held in Albuquerque, N. M., December 7 and 8, the following officers were elected: president, Dr. Percy G. Cornish, Albuquerque, N. M.; vice presidents, Drs. W. Warner Watkins, Phoenix, Ariz., and Charles G. Duncan, Socorro, N. M., and secretary-treasurer, Dr. John R. Van Atta, Albuquerque. El Paso was selected as the next place of meeting.

Mary Pemberton Nourse Fund for Public Health Study.—The Mary Pemberton Nourse Fund for Public Health Study has been established by the class of 1914 of Vassar College in memory of Mary Nourse of that class, who dedicated herself to the cause of public health, but whose aim was cut short of realization. This fund is established for the purpose of offering a fellowship to young women who desire to devote themselves to the important work of public health, and is recommended for consideration by Julia C. Lathrop, chief of the Children's Bureau, United States Department of Labor; Dr. William H. Howell of Johns Hopkins University, School of Hygiene and Public Health, and Henry N. MacCracken, president of Vassar College. The sum at the disposal of the class is to be increased until the income from it will provide opportunity for continued and valuable work in this field. An appeal is now being sent out for gifts of money, and especially of Liberty Bonds, to bring the sum up to the required amount. Coupon bonds and contributions may be sent to the chairman, Katherine Taylor, 330 Webster Avenue, Chicago.

PARIS LETTER

PARIS, Nov. 29, 1917.

Surgery of Nerve Trunks

At one of the recent sessions of the Société de chirurgie de Paris, Dr. Chevrier, hospital surgeon, presented an interesting communication on the technic of the repair of injured nerve trunks. The operation may consist of a liberation, a total suture or a partial suture of the nerve. Chevrier never approaches the nerve at the level of the lesion, but always either above or below, always working without instruments so as not to contuse the nerve; next, he frees it of its coverings; then he scarifies the surface with the point of a bistoury, and, finally, he ensheaths it in amniotic membrane. For total suture, it is convenient, as a preliminary step, to mobilize the nerve for quite a stretch above and below, which favors the bringing together of the nerve ends after the resection. The resection must be extensive enough to obtain a nerve end of the same appearance as is obtained after cutting a normal nerve. Experience has taught Chevrier that he must resect a little more than the hard, indurated mass in the old cases, and a little less than this in the recent cases. The section should be made with a thin, sharp bistoury, not with scissors, because they crush or bruise the nerve. Chevrier makes the section perpendicular to the nerve axis in both stumps. The circular surfaces thus obtained lend themselves to better placing of the suture, and reduce to a minimum the possibility of displacement of the axis cylinder. The suture should aim to be an exact circumferential approximation of the nerve stumps. Chevrier places separate sutures of catgut, including the neurilemma and the most superficial part of the nerve. He puts in many sutures, separated by forceps arranged in order. It is important that when these sutures are tightened the nerve ends are brought together without crushing or bruising. If the nerve ends are not brought in contact by this procedure, the threads are tightened by twisting the ends, going over them in turn several times. The coaptation of the nerve ends may be facilitated by lessening the tension on the nerve itself: flexing the leg for the nerves of the thigh, flexing the forearm to relieve the tension on the median and the radial nerves; extending and adducting to ease up on the ulnar.

PARTIAL SUTURE

In the case of partial suture, the difficulties are found in the resection. It is important that the principle of removing the whole of the indurated fibrous mass must be respected, and that is a difficult matter. By being too conservative, this fundamental principle is not observed. Hence partial resections give results inferior to those obtained with total suture. If the case is one which apparently does not lend itself to a complete resection of the indurated fibrous mass, a resection is nevertheless preferable to a partial suture, even though some normal fibers have to be cut, because a perfect total suture will certainly be followed by regeneration. With this reservation, resection preliminary to partial suture can be effected in several different ways; it may be cuniform, trapezoid or rectangular. The last mentioned is the one preferred by Chevrier, because it gives better approximation. The suturing is done at separate points, but the immediate result does not look so well as that obtained from total suture, because of the hump formed by the sound part of the nerve that has been left intact. The suture completed, the union is wrapped in amniotic membrane.

AFTER-CARE AND OUTCOME

Chevrier insists on the importance of complete asepsis in the performance and after-care of this operation. When the extremity has been placed in an abnormal position for the purpose of lessening the tension on the nerve, it is kept in such a position on an average for three weeks; then it is gradually returned to its normal position. He has never seen a case where the abnormal position became permanent. This technic has yielded the best results; for example: Chevrier's personal experiences in the cases involving the external popliteal nerve are as follows: two liberations, reviewed and followed, have both been cures. Of six total sutures, two were not followed beyond the fourth month, but there is every reason to hope that the result in these cases is a good one. The remaining four cases have been followed and reexamined. They were all cured with complete return of motion.

WALTHER'S TECHNIC

Dr. Walther, assistant professor at the Faculté de médecine de Paris, and surgeon of the hospitals, speaking of the liberation of nerves, said that it is not always possible to accomplish this without the use of instruments as, for instance, when the nerve is included in a mass of thick, fibrous tissue. For some time it has been his practice to effect such liberation with a small, blunt tenotome, used on the flat. As concerns nerve suture, to avoid the turning back of the nerve fibers, which may result from too accurate apposition of the nerve ends, he has followed a method of impacting the nerve ends, hollowing out one end and rounding off the other, so that all the parts of the nerve, especially the central, will be in contact without pressure. He directed attention to a very important question, namely, that of the indication for operation as determined during the operating. Chevrier is guided by the results of electric exploration of nerve function, which is all very well, but when the result is negative, one cannot draw any conclusions as to the nature of the interruption of nerve function; one does not know whether the axis cylinders are embedded in the cicatrix and thus are blocked, or whether they have forced their way through the cicatrix and have penetrated the lower end of the nerve. All that a negative result shows is that the nerve fibers have been completely destroyed. It only remains to determine the position of the lesion and the consistency of the fibrous mass, to decide on the operation to be performed. If there is present a large fibrous mass, well isolated, encapsulated, as it were, a neuroma or a glioma, Walther believes that it is well to remove it, endeavoring, by means of a longitudinal incision, to shell it out, observing all precautions not to bruise or crush the tissues of the nerve embedded in it. When it is a case of diffuse induration, enucleation is out of the question; the only choice is between total resection with suture of the two ends or conservation of the trunk with its cicatricial tissue. In any event, it is convenient to perform the last mentioned operation only if medical treatment, carried on for many months, has failed to show any improvement in the condition of the nerve.

Dr. Quénu, clinical professor of surgery at the Faculté de médecine de Paris, also stated that it is impossible, in certain cases, to know just what part the cicatricial tissue plays; it is wrong to say that this tissue must be removed in every case, especially when such removal would necessitate making extensive resection.

CHAPUT'S TECHNIC

Dr. Chaput, surgeon of the hospitals of Paris, believes that nerve suture can be done by a technic more simple than that of Chevrier. He recommends suture of the neurilemma as being logical in principle, although difficult of execution, because of the possible hernia of the nerve fibers. The conditions for success in nerve suture depend always on the technic employed, local conditions and the general state of the patient. From the point of view of technic, Chaput prefers simple catgut, which is less irritating than silk or chromic catgut. Few sutures should be taken, and they should be placed as near the edge of the nerve as possible so as to avoid the turning back or overlapping of the nerve ends. These sutures should not be drawn tight: the two nerve ends should merely be in contact, and not too closely in contact either, for the postoperative congestion increases the compression of the nerve tissue, and even though the suture is not tight, it brings the ends in contact. Finally, the sutured nerve should not rest on a hard bed, such as bone, but on an interposed muscular bed. The general state of the patient is also of very great importance. First, the age. The operation is not a success in the old; it is much more successful in the young. Alcoholics, syphilitics, those suffering from intoxications, tuberculosis, kidney, liver or heart disease or arteriosclerosis, are in very poor condition for nerve suture, and it is among these that failures are observed most often.

LONDON LETTER

LONDON, Nov. 27, 1917.

The War

VITAL STATISTICS

In his presidential address to the Royal Statistical Society, Sir Bernard Mallet, the registrar-general of births, marriages and deaths, referred to the overwhelming importance of the whole question of racial advance or decline, on which the fate of nations so largely depends, and to the damage that the present struggle must inflict on this and other nations. Dealing with the effect of war on marriages, he said that the number of marriages increased steadily from 260,544 in 1909 to 286,583 in 1913, and that this increase was continued in the first two quarters of 1914. Although the increase in the latter half of 1914 was smaller than that in the earlier half, during the second, third and fourth quarters of 1915 and the first quarter of 1916 a sudden and abnormal rise occurred, and war marriages swelled the totals until they reached "record" heights. Thereafter the increase in marriages continued, but with diminished force, and by the third quarter of 1916 the number had fallen below the average. Crudely stated, he declared that the war has resulted in 200,000 people being married between August, 1914, and June, 1917, who in the ordinary course would not have married. The marriage rate for 1915 was the highest recorded, 19.4; the previous maximum, 17.9, was in 1853.

With reference to the marriage statistics in belligerent countries, he said that in Hungary the effect of the war had been that more than 600,000 people who in the ordinary course would have married had not done so. In Prussia, Bavaria, Saxony, Hesse, Hamburg and Bremen, six states containing more than 80 per cent. of the German population, the total number of marriages in 1913 was 434,103, and in 1914 the number was 392,053, a decrease of nearly 10 per cent., in spite of a great number of war marriages during the first month of the war. From figures available, in Saxony, compared with the last year of peace, the decrease was about 35 per cent., in Hamburg 24.5 per cent., in Bremen 37.6 per cent., and in Berlin 21.6 per cent., and he presumed that the decrease in the country was greater than in the town.

Comparing the statistics, the president said that the very notable difference was not difficult to account for. In Germany the whole population of military age was mobilized; in England war marriages were stimulated by generous allowances and pensions. On the introduction of compulsory service, larger numbers of men of marriageable age were fighting abroad, and the conditions were beginning to approach those of the Germans, the influence of which could be seen in the birth rate, although the comparison was wholly in favor of this country.

The loss of potential lives to the belligerent countries by the decrease in the numbers of children was, perhaps, the most important effect produced by the war on vital statistics. It was first felt at the end of April, 1915, and it would continue until nine months after the termination of hostilities and demobilization was more or less completed. In England and Wales, in the three years 1911-1913, the decrease in the births amounted to 4.2 per cent. in numbers as compared with 1908-1910, and represented a birth rate of 6.3. In Germany the decrease had been much more rapid of late years; the decline was 5 per cent. in numbers and 9 per cent. in rate, and in Hungary 1.1 and 3.5. From these figures it was apparent that the United Kingdom had suffered far less than had Germany in this vitally important point. The United Kingdom lost by the fall in births over 500,000 potential lives, approximately 10,000 per million of the population. Germany lost in the same period 2,600,000 approximately 40,000 per million. Hungary lost 1,500,000, approximately 40,000 per million. At the outbreak of war, the population of the central empires was about two and a half times as great as that of the United Kingdom; their losses of births had apparently been ten times as great. The poorer classes in this country had never experienced more favorable conditions, but the Germans, if all indications were to be believed, had suffered to such an extent as to affect seriously the general health of the population.

As regards infant mortality, the rate during 1914-1916 had been lower both in the United Kingdom and in Germany

than in any previous period of like duration; but the summer mortality in 1917 appeared to have been extraordinarily high in several German cities in spite of the great organized efforts to save infant life, and the German rate all through remained at about 50 per cent. higher than in this country. The rate recorded in the United Kingdom in 1916 was the lowest on record. In speaking of the deaths during the period of the war, Sir Bernard Mallet distinguished between civilians and members of the armed forces. Generally there was a marked rise in civilian deaths in 1915, followed by a fall to below prewar numbers in 1916. One cause of the decrease was the restrictions in the output of alcoholic liquors.

FOOD CONTROL: BAN ON SALE OF CREAM

New orders have been issued by the food controller. The use of cream is prohibited except for the purpose of making butter or for consumption by invalids, young children, or other persons on a physician's order. The order has been issued to conserve as much full milk as possible, and because the use of cream has been chiefly a luxury.

Another order prohibits the use by brewers of any saccharin substance other than solid glucose or the invert or other product of low-grade sucrose polarizing not over 89 degrees, and from which not less than 40 per cent. of its weight has already been extracted in the form of grocery crystal sugar, honey, sugar or syrup. Brewers are, however, permitted to use their existing stocks or any sugar that was in transit to them, at the date of the order, from the manufacturers. The quantity of such saccharin substance that brewers are permitted to use is not more than 40 per cent. of the quantity used by them in the year 1915.

THE SURGICAL TREATMENT OF DISABLED MEN

In a lecture delivered at the Royal Institute of Public Health, Col. Sir Robert Jones, inspector of military orthopedics, said that wounded and disabled men form a serious proportion of the population, and must be helped to remain an economic part of the man power of the nation and not mere helpless dependents. Fully 50 per cent. of the wounded in this war suffered from injuries which either are or may become physical disabilities, the treatment of which is orthopedic. There are now a large number of orthopedic centers started or on the point of being started all over the country, providing accommodation for from 1,400 to 1,800 men each, completely equipped. They consist of special departments, each directed by specially trained surgeons. The heads of these departments hold consultations in doubtful cases. Sir Robert Jones defined orthopedics in relation to military surgery as the treatment by operation, by manipulation, by construction and by reeducation, of disabilities to arms and legs arising from injury or disease. The orthopedics of war he divided into preventive and corrective. Owing to the fact that most gunshot wounds are already septic when the wounded reach surgeons at the front, their energies are taxed by the effort to save life, and many patients reach England with various types of deformity and considerable shortening of the limb. The first duty of the orthopedic surgeon is to consider how the limb—a fractured thigh, for instance—may be lengthened, and lateral deflection, which produces almost complete loss of function of the limb in walking, remedied. When the patient has been made to walk with an apparatus that prevents fresh shortening of the limb, he is only improved, not cured; he is therefore retained in the orthopedic center until his joints become supple and his muscles are developed by intensive methods, including special forms of electric massage and exercises. Again, in the case of a stiff wrist or stiff elbow with, perhaps, loss of part of one of the bones of the forearm, the surgeon first mobilizes the joints, and then, if need be, grafts a piece of shin bone into the arm, the patient being kept in the hospital until the function of the arm is well on the way to restoration. In cases of nerve injury, it is necessary first to mobilize the joints and afterward to operate by nerve suture or tendon transplantation. In the case of a man with a helpless flail hand, certain muscles, which can be spared in the front of the forearm, are attached to paralyzed tendons; in three months the patient may be able to raise his hand. Another military orthopedic problem is to decide, when the elbow-joint, for instance, must be stiff, what is the best position in which to fix it. Usually a stiff elbow fixed at a suitable angle is better than a weak joint; but men engaged in certain trades find a movable though weak elbow more useful than a stiff joint. A great change in the morale of the men in orthopedic centers has been brought about by the progress of military orthopedics. At first they had grounds for fearing that if they accepted treatment designed for partial or complete restoration of function, their pensions would be reduced. Now the mental attitude of the patient is altered by the fact that pensions are based on physical disability without reference to earning power, and that there are penalties in the form of reductions if treatment is refused. Men are now open to the persuasion of the hospital staff and of cured comrades; they derive direct benefit, mental and physical, from curative workshops. The governing principle of curative work is that voluntary movements are of infinitely greater value than passive movements. When the vast installations of Zander instruments and the way they are employed are considered, Sir Robert Jones considers it amazing that more tragedies do not take place. One gentle movement in every direction of a stiff elbow might overcome adhesions; to repeat the movements in a machine only endangers the tissues by direct irritation. Exercises practiced in curative workshops are of two kinds, direct and indirect. The ingenuity of the instructor is shown in devising direct curative work suitable to each case; but the indirect method is often the best. For example, when a man with a stiff ankle is set to plane or saw wood, he unconsciously uses the ankle as he becomes interested in the work his hands are doing. Again, if a man with stiff fingers who cannot hold any tool is given something to do with the other hand, the crippled hand will come to the rescue in a difficulty and soon become useful. Owing to the control that surgeons at the front have obtained over gas gangrene and sepsis, the number of amputations is diminishing. Further expansion of orthopedic centers has been authorized with the object of getting patients directly from the front in order that the occurrence of deformity may be anticipated.

A man discharged from the army to civil life passes under the care of the Ministry of Pensions, which possesses great responsibilities and great powers for good. It cannot compel a pensioner to undergo training, but it can bring pressure to bear on him, for if treatment short of operation is refused, the pension is reduced, while bonuses are given to men who train, and, if they are married, a separate allowance. Many pensioners will require treatment for two or more years, but it can be carried on while they work or train. Patients discharged from orthopedic centers to civil life fall into two groups, Orthopedic A, consisting of the partially disabled who require further treatment of an orthopedic kind, and Orthopedic B, who require a certain amount of treatment of a general kind. The orthopedic centers supply to the first class a ticket giving a note of the patient's condition, with suggestions to the pension authorities as to the treatment required.

A Ten Months' Child: A Physician's Divorce Case

The old question of the possibility of ten months' gestation, and the consequent one of the legitimacy of a child when connubial intercourse last took place at the beginning of that period, have been fought out again in the law courts. The case is important because it brought to light the experience of our leading obstetricians on the point—a kind of up-to-date symposium. The petitioner, a captain in the Army Medical Corps, sought to divorce his wife on the grounds of adultery. The marriage took place, June 17, 1915. Neither he nor his wife desired to have children till the war was over. Dec. 19, 1915, they cohabited for the last time before he left for Egypt, but, the petitioner alleged, under circumstances that prevented pregnancy. The wife went to her brother in the country at a house where three officers were staying. Then she went to stay with some friend, and menstruated there. Jan. 19, 1916, she went to her father's house, and the suggestion was that between her stay at the last place and coming to her father she comitted adultery with an unknown man. March 10, 1916, she underwent an operation for appendicitis, when it was found that she was pregnant. March 20, she wrote to her husband informing him of the fact. He replied that her statement was absurd, that he was a physician and was convinced that nothing of the kind could ever have happened. Oct. 22, 1916, she gave birth to a child of normal period. Between her husband's leaving England and the birth of the child, 307 days elapsed. The following expert evidence was given for the husband: Dr. H. R. Spencer, obstetric physician to University College Hospital, said that he had known a case of gestation of 307 days from what he had been told was the last day of menstruation. He did not think that the husband in this case could possibly be the father. The operation could not have tended to prolong gestation. Dr. Griffith, obstetric physician to St. Bartholomew's Hospital, said that in protracted gestation the labor would be slow; but he admitted that he had known cases of ten months' children with normal delivery. For the respondent, Dr. Philips, obstetric physician to King's College Hos-

pital, said that he had experience of three cases, one of 298 days, the second of 306 days, and the third of 308 days, in each of which the husband had left the country for these periods. It was not impossible to have a ten months' child. In her evidence the petitioner said that her menstrual period ended December 18, and that she had proper intercourse with the petitioner, December 19. The judge (Mr. Justice Horridge) said that he believed the respondent, and that the case was one of protracted gestation. He therefore gave judgment in her favor.

Marriages

CHARLES NORTHMORE STURTEVANT, M.D., Frankford, Philadelphia, to Miss Martha Irvine of Mercersburg, Pa., at Frankford, December 8.

LIEUT. KENNETH ALLEN PHELPS, M. R. C., U. S. Army, West Point, N. Y., to Miss Ora Shaffner of Burlington, N. C., December 5.

LIEUT. EMERY BOWERS NEFF, M. C., U. S. Army, Fort Ringgold, Texas, to Miss Ruth Heath of Houston, Texas, November 27.

LIEUT. SAMUEL L. WADLEY, M. R. C., U. S. Army, to Miss Bertha Elizabeth Rahm, both of Memphis, Tenn., December 5.

MARVIN H. PORTERFIELD, M.D., Martinsburg, W. Va., to Miss Catherine E. MacLuckie of Frostburg, Md., November 6.

S. MURRAY HOUTZ, M.D., to Mrs. Crace M. Moist, both of West Berwick, Pa., at Beach Haven, Pa., October 23.

HENRY ERNEST RICKETTS, M.D., Belleville, N. J., to Miss Mary T. McCue of Newark, N. J., November 17.

FRANCIS STEPHEN CALDICOTT, M.D., Woburn, Mass., to Miss Helena Stanfield of Louisville, Ky., recently.

SAMUEL DUNCAN CAMERON, M.D., to Miss Laura Brouillard, both of North Yakima, Wash., October 25.

SMITH ELY JELLIFFE, M.D., to Miss Bee Dobson, both of New York City, December 3.

GEORGE CRESSWELL DAVIS, M.D., to Miss Nelle Bound, both of Milton, Pa., December 1.

JESSE CARROLL COGGINS, M.D., to Miss Mabel McCahan, both of Baltimore, December 8.

JAMES A. KIERNAN, M.D., Chicago, to Miss Grace Cole of Alton, Ill., December 10.

Deaths

Everett James McKnight, M.D., a member of the Board of Trustees of the American Medical Association, died suddenly at his home in Hartford, Conn., December 25, from angina pectoris. Dr. McKnight was born June 12, 1855, in Ellington, Conn., and was graduated from Yale University with the degree of A.B. in the class of 1876. After a year of study in Yale Medical School he entered the College of Physicians and Surgeons in the City of New York, from which he was graduated in 1879. Since that time he has practiced in Hartford and East Hartford, specializing in surgery, and at the time of his death was in active service on the staff of the Hartford Hospital. He was an enthusiastic Yale man, and made the arrangements for the first intercollegiate football game between Yale and Harvard. His alma mater gave him the degree of A.M. in 1907. He served as president of the Connecticut State Medical Society in 1907-1908, and of the Hartford Medical Society in 1914. He represented the town of East Hartford in the General Assembly in 1893, and was chairman of the committees on fisheries and public health.

His official connection with the American Medical Association commenced in 1908, when he was elected a member of the House of Delegates and continued until his election to the Board of Trustees in 1916. His last official work for the Association was as a member of the War Committee, regarding the appointment of advisory boards for the new selective draft.

One of his associates pays him this tribute: "We all put work on him, from the government down to his humblest friend, because he was so capable; then we put more work on him because he was so willing. He worked for others until the last minute." Dr. McKnight was an earnest and conscientious worker, with a humanitarian interest in his fellow men. When he gave himself to a cause he labored with complete devotion to its accomplishment.

Edward Mathew Hanson, M.D., Keokuk, Iowa; Keokuk (Iowa) Medical College, 1892; aged 49; a Fellow of the American Medical Association, and a specialist on diseases of the eye, ear, nose and throat; professor of electrotherapeutics in Keokuk Medical College of Physicians and Surgeons; eye, ear, nose and throat surgeon to Graham Hospital, Keokuk; who had been suffering from a nervous breakdown; died at the home of his cousin in St. Louis, December 11, from the effects of carbolic acid, self-administered, it is believed, with suicidal intent.

Charles H. North, M.D., Dannemora, N. Y.; University of Buffalo, N. Y., 1898; aged 49; a member of the Medical Society of the State of New York, and American Medico-Psychological Association; who entered the state service after graduation as assistant physician at the Matteawan Hospital for Insane Criminals, was transferred to the Dannemora State Hospital for Insane Felons, on its opening in 1900, and was made superintendent of the institution in 1904; was stabbed and almost instantly killed by an insane inmate, December 12.

Capt. Zotique Rousseau, M. R. C., U. S. Army, Troy, N. Y.; Laval University, Quebec, 1869; aged 71; formerly a Fellow of the American Medical Association; a member of the Medical Society of the State of New York, and for several terms president of the Rensselaer County Medical Society; on duty at Watervliet Arsenal; for more than forty years attending physician at the Troy Hospital; physician to the Home of the Aged Poor, and for the House of the Good Shepherd; died at his home, December 6, from pneumonia.

Jesse Snodgrass, M.D., Kenton, Ohio; Bellevue Hospital Medical College, 1867; aged 77; formerly a Fellow of the American Medical Association; a member and once assistant secretary of the Ohio State Medical Association; at one time president of the Northwestern Ohio Medical Association; a specialist on diseases of the eye, ear, nose and throat; assistant surgeon of the Eighth Tennessee Volunteer Infantry during the Civil War; who underwent operation several months ago, died at his home, December 8.

Orran George Cilley, M.D., Boston; Dartmouth Medical School, Hanover, N. H., 1868; aged 77; for several years coroner; from 1873 to 1879, surgeon of the First Squadron Cavalry, M. V. M.; surgeon-general of Massachusetts in 1883, under Governor Benjamin F. Butler; for four years physician to the Charles Street Jail; died at his home, December 9.

Albert Stone Gray, M.D., Chicago; Bennett College of Eclectic Medicine and Surgery, Chicago, 1887; College of Physicians and Surgeons, Chicago, 1889; aged 53; for several years a contributor of articles on health topics to the daily press; died in St. Luke's Hospital, Chicago, December 17, from anemia.

John Royer Laughlin, M.D., Hagerstown, Md.; George Washington University, Washington, D. C., 1906; aged 45; formerly a Fellow of the American Medical Association; a member of the Medical and Chirurgical Faculty of Maryland; died in Hallendale, Fla., December 14, from arteriosclerosis.

Charles Francis House, M.D., Painesville, Ohio; Long Island College Hospital, Brooklyn, 1874; aged 69; formerly a Fellow of the American Medical Association; for several terms president of the Lake County (Ohio) Medical Society; died at his home, December 12, from a nervous breakdown.

Charles S. Payne, M.D., Liberty, N. Y.; University of Buffalo, N. Y., 1884; aged 57; formerly a Fellow of the American Medical Association; a member of the Medical Society of the State of New York; died at his home, December 12, from cerebral hemorrhage.

Amos H. Helm, M.D., New Providence, Pa.; Jefferson Medical College, 1868; aged 72; a member of the Medical Society of the State of Pennsylvania; for forty years a school director; died suddenly from heart disease, December 10, while shoveling snow in his yard.

Andrew W. Tracy, M.D., Meriden, Conn.; McGill University, Montreal, 1873; aged 71; a member of the Connecticut State Medical Society; mayor of Meriden in 1892, and a member of the city council for two terms; died at his home, December 10.

Guido L. Stempel, Macedonia, Iowa (license, Iowa, years of practice, 1886); aged 82; formerly a member of the Iowa State Medical Society; a well known naturalist and collector of birds and butterflies; died at his home, December 13, from nephritis.

R. M. Montgomery, M.D., Hazlehurst, Ga.; Medical College of the State of South Carolina, Charleston, 1897; aged 52; a member of the Medical Association of Georgia; died in a sanatorium in Hazlehurst, December 2, from acute gastritis.

John Heard Ford, M.D., Vinton, La.; Louisville (Ky.) Medical College, 1893; aged 48; a member of the Louisiana State Medical Association; died at his home, August 2, from tumor of the brain, four weeks after a surgical operation.

Murdoch Chisholm, M.D., Halifax, N. S.; McGill University, Montreal, 1879; L.R.C.P. (Lond.), 1886; professor of clinical surgery in Dalhousie University, Halifax; was killed in the explosion which devastated Halifax, December 6.

Simon Elston Hooper, M.D., West Branch, Mich.; Western University, London, Ont., 1890; aged 54; a Fellow of the American Medical Association; died at his home, November 30, from septicemia, due, it is said, to pyorrhea.

John P. Logan, Dewitt, Mo. (license, Missouri, 1883); aged 63; for forty-two years a practitioner; formerly a member of the Missouri State Medical Association; died in St. Joseph's Hospital, Kansas City, December 4.

Albert Leroy Ward, M.D., Bement, Ill.; Chicago Homeopathic Medical College, 1899; aged 47; formerly a member of the Illinois State Medical Society; died in Decatur, Ill., September 21, from typhoid fever.

Richard Wallopie Kent, M.D., San Francisco; New York University, New York City, 1886; surgeon in the Pacific Mail Steamship Company's service; died in Calcutta, India, September 30.

Andrew Kamerling, M.D., Buffalo; University of Buffalo, 1866; aged 78; formerly a member of the Medical Society of the State of New York; died at his home, about December 6.

Adelaide Lambert, M.D., New Haven, Conn.; Boston University School of Medicine, 1884; aged 64; a member of the Connecticut State Medical Society; died recently at her home.

James Henry Knight, M.D., Morgantown, Ind.; Bellevue Hospital Medical College, 1875; formerly an assistant surgeon in the United States Army; died at his home, December 4.

Anseel McKinstry Whitbeck, M.D., Brooklyn; aged 81; a practitioner since 1859; died at the home of his daughter in Brooklyn, December 4, from senile debility.

William Caldwell Stevens, M.D., Worcester, Mass.; Harvard Medical School, 1883; aged 62; a Fellow of the Massachusetts Medical Society; died at his home, October 17.

S. A. Reasons, M.D., Waldo, Ark.; Memphis (Tenn.) Hospital Medical College, 1894; aged 49; also a druggist; died in a hospital in Little Rock, Ark., December 5.

Samuel Hastings Brown, M.D., Philadelphia; Hahnemann Medical College, Philadelphia, 1869; aged 72; died at his home, November 21, from cerebral hemorrhage.

Frank Marion Foote, M.D., Marshall, Mich.; University of Michigan, Ann Arbor, 1884; aged 56; died at his home, October 28, from pulmonary tuberculosis.

Frank B. Black, M.D., Gilboa, Ohio; Eclectic Medical Institute, Cincinnati, 1886; aged 65; died in a hospital in Cincinnati, December 5, from typhoid fever.

John Calvin Cummings, M.D., Harrisburg, Pa.; University of Maryland, Baltimore, 1884; aged 63; died at his home, November 6, from cerebral hemorrhage.

Joseph H. Matthews, M.D., Lollie, Ark.; University of Arkansas, Little Rock, 1893; aged 48; died at the home of his niece in Conway, Ark., December 6.

B. F. Zeller, M.D., Union City, Ind.; Medical College of Ohio, Cincinnati, 1875; aged 72; a veteran of the Civil War; died at his home, November 29.

Ira N. Noland, M.D., Cleveland; Western Reserve University, Cleveland, 1892; aged 73; a veteran of the Civil War; died at his home, December 2.

John A. Blaydes, M.D., Hot Springs, Ark.; Transylvania University, Lexington, Ky., 1857; aged 83; died at his home, August 18, from pneumonia.

William H. King, M.D., Derry, Pa.; Jefferson Medical College, 1870; aged 68; died in the Columbia Hospital, Wilkinsburg, Pa., December 5.

Wilbur F. Curtis, M.D., Chicago; Bennett Medical College, Chicago, 1890; aged 63; died at his home, December 9, from heart disease.

Lewis A. Lee, M.D., Conyers, Ga.; Atlanta (Ga.) Medical College, 1878; aged 60; died in a sanatorium in Atlanta, December 5.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER MATTER TENDING TO AID INTELLIGENT PRESCRIBING AND TO OPPOSE MEDICAL FRAUD ON THE PUBLIC AND ON THE PROFESSION

NOSTRUMS IN RETROSPECT

A Review of Worthless or Unscientific Proprietary Mixtures Previously Criticized

[FOREWORD.—The article that follows is the third[1] of a series written primarily for the purpose of reviewing the findings of the Council on Pharmacy and Chemistry on certain unscientific or worthless proprietary mixtures. Although the preparations which will be taken up in this series have been extensively dealt with in previous reports, the fact that they are still widely advertised and sold indicates the need of further publicity. The series is written by a man who is thoroughly conversant with the work of the Council on Pharmacy and Chemistry and can speak authoritatively on questions dealing with the actions of drugs in the treatment of disease.]

[ARTICLE III]

PEPTO-MANGAN

S. Q. Lapius, M.D.

It would be interesting, and even instructive, to know how many educated physicians, if any, are now prescribing Pepto-Mangan (Gude): Interesting as indicating the number who have neglected to avail themselves of the work of the Council on Pharmacy and Chemistry, especially the earlier work; instructive in that it would show how many are still prescribing by the rule of thumb, and who are taking their therapeutic instructions from purely commercial sources instead of striving to learn how to choose those drugs that are most effective in the treatment of disease.

It has been pointed out many times in the pages of THE JOURNAL that many nostrums are advertised first to physicians, and that after physicians have served as the unpaid agents of the manufacturers in introducing the preparations, their exploitation is then commonly continued by means of advertisements in the public press. This plan has been followed successfully in so many cases that we have now come to look on it as the regular course. It is in keeping with this rule that we find Pepto-Mangan now advertised in the public press, the physician having served the manufacturer's purpose.

DISCARDED THEORIES OF IRON MEDICATION

It will be recalled that many years ago the theory was held that hydrogen sulphid (sulphuretted hydrogen) interfered with the absorption of the iron of the food, and that the administration of medicinal iron prevented this interference by neutralizing the hydrogen sulphid (sulphuretted hydrogen). It was only a short step to argue that manganese might replace the medicinal iron in combining with the hydrogen sulphid, permitting the food iron to be absorbed, and it was held that only food iron could be utilized in the formation of hemoglobin.

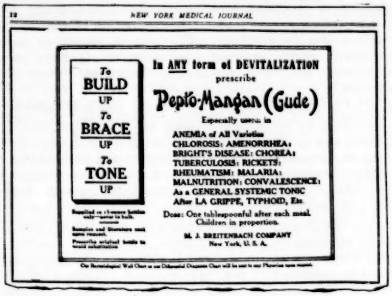
It is hardly necessary to remind the reader that this theory rests on numerous fallacies. There is no hydrogen sulphid worth mentioning in the small intestine where iron is absorbed; food-iron cannot be utilized directly in the formation of hemoglobin but must be broken into simple forms for absorption; and, further, inorganic iron, such as ferrous carbonate, serves the purpose admirably where iron is indicated. With the acceptance of these well-established facts all possible excuse for the therapeutic employment of Pepto-Mangan in place of iron vanished, but as plain and simple as this fact is, the unnecessary and expensive Pepto-Mangan continues

1. The previous articles of the series are "Bell-ans," THE JOURNAL, Nov. 24, 1917; "Anasarcin and Anedemin," THE JOURNAL, Dec. 8, 1917.

to be prescribed by physicians who will not take the slight trouble to investigate the claims for this nostrum.

FALSE AND MISLEADING CLAIMS

That there is not merely a difference of opinion on the part of the exploiters and the Council, but that actual misrepresentation has been employed in the exploitation of this nostrum to physicians has been shown on more than one occasion. About twelve years ago the M. J. Breitenbach Com-



From the *New York Medical Journal.*

pany, the proprietors of Pepto-Mangan, claimed that the report of the Commission that had been appointed for the investigation of anemia in Porto Rico "would alone suffice to establish Pepto-Mangan at once as the foremost hematinic known." Examination of the report showed that the Commission made no such claims; on the contrary the Commission protested against this misrepresentation. (THE JOURNAL A. M. A., Oct. 7, 1905, p. 1099.)

Undaunted by this exposure of their methods, the Breitenbach Company later sent out a statement of results purporting to have been obtained by one Mateo M. Gillen, in the treatment of infantile anemia on Randall's Island in New York City. At the instance of THE JOURNAL the hospital records in these cases were examined, and it was found that the pretended report was little more than a tissue of falsehood. (THE JOURNAL A. M. A., April 6, 1907, p. 1197.)

About two years ago the Council reported that while the statements just referred to were no longer made, they had never been definitely admitted by the Breitenbach Company to be erroneous, and that Pepto-Mangan was then being exploited to the public indirectly. (Council Reports, 1914, p. 121.)

We reproduce an advertisement that has been appearing weekly in the *New York Medical Journal* for several months. One can only suppose that this advertisement was intended to mislead physicians, and it would be an insult to the intelligence of the average reader to attempt any detailed discussion of it, but enough has been said to show how misleading the statements are. One should note particularly the advice —old as the nostrum business itself—contained in the advertisement, to prescribe an original bottle. The reason for such advice is simple. Experience has shown that when original bottles are dispensed patients soon learn to buy the nostrum without consulting the physician, for they shrewdly suspect that he knows no more about the preparation than they, and that he gets his information from precisely the same sources that are available to them. They are obviously right. In truth, the physician who prescribes Pepto-Mangan as a hematinic shows ignorance of the most rudimentary facts of iron therapy, and the intelligent patient soon perceives his limitations.

THE PROBLEM OF IRON THERAPY

The investigation of the problems of iron therapy and its utilization in the formation of hemoglobin forms one of the most brilliant chapters in pharmacologic research, and there is no better established fact in therapeutics than that any organic or inorganic preparation of iron that does not irritate the stomach may be employed effectively when the administration of iron is indicated. "Useful Drugs" contains a list of iron preparations that are suitable for all conditions which call for iron, and the clinician may rest assured that he will never have occasion to go outside of that list to prescribe any substitute.

As a matter of fact, it seems probable that the very number of available iron preparations has served to cause confusion, thus affording an opportunity for the nostrum maker to introduce his superfluous compounds. It may be difficult at times to select the preparation of iron best suited to the individual patient and it is this difficulty that has led the clinician to listen to the seductive claims made for the various pretended substitutes for iron. One should approach the question of choosing the proper form of iron for therapeutic use with the recognition of the fact that there is no such thing as a substitute for iron in the formation of hemoglobin, that there are no ideal forms of iron other than those found in the foodstuffs. Further, the clinician cannot avoid the disadvantages inherent in all forms of iron that he can prescribe, and he must therefore seek that which seems best suited for the individual patient.

Bunge estimated the amounts of iron present in various foods and a table based on this, and other data, is given in "Pharmacology of Useful Drugs" (published by the American Medical Association). Ordinary foods in an ample diet contain enough iron to supply the normal daily loss, which amounts to only a few milligrams, but many persons who have poor appetites take an insufficient amount of iron in their food and become anemic. In such cases the additional iron required can be supplied best by adding spinach, eggs, apples, or other iron-rich food to the dietary.

SOME IRON COMBINATIONS

William Hunter discusses the subject of anemia and its treatment at considerable length in the "Index of Treatment,"

A newspaper advertisement of Pepto-Mangan.

Ed. 6, pp. 17-37, and gives many prescriptions containing iron for use under different conditions, and while it is unnecessary to reproduce all of these here, a few may be given in order to suggest suitable methods of prescribing iron when it cannot be given in sufficient amounts in the food.

In chlorosis Hunter advises that that form of iron which experience has shown to be least disturbing to the patient's

stomach should be used, and he suggests separate stomachic mixtures to be used simultaneously not mixed with the iron itself. Where constipation exists—and this is a very common accompaniment of chlorosis—he gives the following aperient iron combination:

Ferrous sulphate	gr. iv
Magnesium sulphate	ʒ i
Aromatic sulphuric acid	♏ vii
Tincture of ginger	♏ x
Compound infusion of gentian (B. P.) q. s., ad	ʒ i

This, constituting a single dose, is to be taken twice daily—at 11 a. m. and 6 p. m. A little compound tincture of gentian and water may be used in place of the compound infusion of the British Pharmacopeia. He modifies this somewhat as occasion demands by using sodium sulphate and adding bicarbonate of sodium (which converts the sulphate of iron into ferrous carbonate) and adds 10 minims of spirit of chloroform to act as a stomachic.

Hunter also suggests the use of pills of aloes and iron in place of the above mixture, and when constipation has been corrected the aloes may be omitted and the pill of ferrous carbonate alone may be used for the iron. Hunter's comment regarding this pill is: "very satisfactory."

The same form of iron is available in the compound iron mixture, formerly official, which Hunter says is exceedingly good. In this country the compound solution of iron and ammonium acetate, Basham's mixture, so called, has long enjoyed a wide reputation as causing very little disturbance of the stomach, and the homely tincture of ferric chlorid is probably useful in a large majority of cases in which the stomach is not especially irritable.

We may say with assurance that one of the forms suggested here will suffice for practically every case in which it is necessary to reinforce the amount of iron available in the food by some pharmaceutical preparation. If these do not satisfy your requirements consult a really competent pharmacist and enlist his aid in devising a mixture especially suited to your individual patient.

Correspondence

THE ROENTGEN RAY IN TREATMENT OF EPILEPTIC SUBJECTS OF STATUS LYMPHATICUS

To the Editor:—In Bellevue Hospital the diagnosis of status lymphaticus by simple inspection of the body is frequently made, both in the wards and in the necropsy room—in the latter place without the clinical history and before proceeding with the systematic examination of the viscera. In the male, the configuration of the body in status lymphaticus is of the female type—the face is beardless or nearly so, and the axillary and other hairs are scanty, the skin is smooth and of an unusually delicate texture, the pubic hairs are sharply defined in a transverse direction, the waist is slender and sloping, and the thighs are gracefully arched both laterally and anteriorly. In the female, the diagnosis is rather more difficult, and rests largely on features that are only an accentuation of those normally encountered, namely, the thin, delicate skin, the narrow waist and the arched thighs, together with the small axillary pads and the scanty growth of hair on them.

In the psychopathic pavilion at Bellevue Hospital, it has been noted by Dr. Karpas that many epileptics present the external peculiarities of status lymphaticus; and it is a well known clinical fact that epileptic seizures not uncommonly cease at or about the age of puberty, in other words, at a period when the thymus undergoes involution. Ohlmacher has pointed out the resemblance between epileptic seizures and the symptoms that sometimes precede sudden death in subjects of status lymphaticus. In the pathologic laboratories at Bellevue Hospital I have often had occasion to observe the presence of myriads of acute necroses in the lymphoid tissues in subjects suddenly dead with all the physical attributes of status lymphaticus, and have advanced the theory (*American Journal of Diseases of Children*, 1917, **14**, 463) that these necroses represent the structural expression of sensitization of the tissues to toxic nucleoproteins, and that the convulsive seizures in certain epileptics and sudden death in other subjects of status lymphaticus are of the nature of anaphylactic phenomena.

I should appreciate an opportunity, through the medium of THE JOURNAL, to direct the attention of radiologists to these facts and to suggest that epileptics with the external configuration of status lymphaticus be systematically subjected to radiation, particularly in the region of the thymus, the spleen and the intestine. The several groups of superficial lymph nodes are not commonly enlarged in status lymphaticus, and are apparently negligible from this standpoint.

It is of interest to observe that many soldiers, exposed to the terrifying vicissitudes of trench life, have been invalided to France and England with symptoms of exophthalmic goiter varying in intensity from simple tremor and tachycardia to the fully developed picture; that almost every subject of exophthalmic goiter examined postmortem reveals hyperplasia and persistence of the thymus, together with the other anatomic features of status lymphaticus, and, finally, that the British radiologists have reported remarkable results in exophthalmic goiter in returned soldiers who have been exposed to radiation of the thyroid gland (White, C. P., and Hernaman-Johnson, F.: *Lancet*, London, 1916, **1**, 78. Stoney, F. A.: Ibid., 1916, **1**, 777). In these circumstances it is possible, I think, that the anatomically related thymus has come in for a share of radiation, and that improvement is to be traced partly to this effect.

At all events, the use of the roentgen ray is known to discourage the proliferation of lymphoid tissues, and its employment in epileptic subjects of status lymphaticus appears to be a procedure justified by anatomic considerations.

DOUGLAS SYMMERS, M.D., New York.
Assistant Director of Laboratories, Bellevue and Allied Hospitals.

CHARCOT'S OPINION AND CRITICISM OF GERMAN MEDICINE

To the Editor:—Ten years after Sedan and thirty-three before the present war, the great French physician Charcot in his "Lectures on Senile Diseases," page 20, indulges in comment on French, German and English medicine that is perhaps more striking now than when it was written. It will probably be interesting to the 20,000 physicians who have already volunteered in the medical service of our country.

The pride of the Frenchman in Laennec and the stethoscope is evident. The slow waking up of the German to modern scientific medicine, and the influence of Schönlein, of purpura fame, and of Rokitansky is charmingly described. The keen terseness of the French is evident when he refers to "the science from beyond the Rhine." In the last two paragraphs he accuses Virchow of abusing "the word science in order to excite German minds for the sake of a narrow patriotism." His contrast of "the exclusive and illiberal ideas of the Prussian savant" with "the grand words of one of England's greatest physicians" is striking. The Englishman is Graves, of exophthalmic goiter fame. My copy of Charcot was issued by the New Sydenham Society in 1881, translation by Tuke.

"But, some will say, what use are these big words and grand ideas? Have the scientific tendencies about which you make so much fuss had a beneficial influence on the practice of the art? Do you cure more patients than they cured of old? These, gentlemen, are very indiscreet questions, and might easily be thrown back at our adversaries. Let it suffice to reply, with an honored teacher, that art without science is not slow to degenerate into routine [Béhier]. That hackneyed skepticism, which people so willingly oppose to all progress of the human mind, is a comfortable pillow for lazy heads; but the period in which we live allows no time for falling asleep.

"To put in its true light the happy influence which scientific tendencies may have on the advance of medicine, I need only

recall to you the remarkable transformation which in the course of the last twenty years this science has undergone in a neighboring country to ours, in Germany. Let us transport ourselves a moment across the frontier, and go back in thought toward the year 1830. At that time Schelling and his audacious 'Philosophy of Nature' reigned absolute masters over German minds. The fashion was for poetic points of view and transcendental conceptions, while a physician allowed himself in a treatise on mucous fever seriously to compare a blood corpuscle to the terrestrial globe, because both are round, flattened at the poles, and possess a central nucleus surrounded by an atmosphere [H. Horn].

"During this time medicine was thus reduced to a deplorable condition. Although they possessed translations of the chief pathological works recently published in France and England, yet the progress long accomplished in these two countries remained as though it had never taken place, for none of them understood its importance. An accurate local diagnosis was never made either in hospital or in private practice. In more than one German university the stethoscope was almost unknown; if anybody happened to come across one of these instruments he examined it with a sort of infantile curiosity, or received with unfavorable jokes those eccentric individuals who, by means of this bit of wood, professed to hear unheard of things. Besides, most chest and heart diseases, as well as chronic skin affections, formed an almost unexplored territory. And when they began to talk of the French it was only to ridicule, this time with more show of justice, the curious mania which made them look on all diseases as inflammations [Wunderlich].

"Things remained thus till near 1840. Then began the work of regeneration (chiefly through Schönlein's influence) by the introduction of the French methods into clinical work. Then it was the turn of morbid anatomy, brilliantly represented at Vienna by Rokitansky. But already Müller had appeared in physiology, and soon created morbid histology, which was long to remain an almost exclusively German science.

"Gentlemen, you know the rest. The German universities presented the spectacle, new to them, of an unheard of, almost feverish, activity; and you are not ignorant that this fever for work, which does not yet seem near extinction, has already produced more than one work of fundamental importance.

"For more than ten years this great intellectual movement remained almost unnoticed in France. From time to time some foreseeing observer tried to draw public attention to it; but there was general indifference to struggle against, and, whilst everything was astir in Germany, we in France were occupied with other matters. At last the day has come, and it is understood that a great power has arisen in our vicinity, so that we shall have in future to reckon with the science from beyond the Rhine. [This lecture was given in 1867.]

"By a very natural reaction people soon got to think extravagantly of the tendencies they had at first opposed; and whilst in France we are perhaps too much inclined nowadays to think nothing of other than German work, our neighbors, drunk with success, seem persuaded that for the future the empire of Science belongs to them. Gentlemen, we must know how to allow something to the inebriation of such a triumph. Yet it is not without regret that we have recently seen an eminent man confound the rights conferred on him by his high position as a savant with the political mandate entrusted to his charge by the electors of Berlin, and abuse the word science in order to excite German minds for the sake of a narrow patriotism [in allusion to a discourse of Virchow's at the Congress of German Naturalists, September, 1865]. Nobody should forget that science owns no country and is the property of no race. With the exclusive and illiberal ideas of the Prussian savant, we will contrast the grand words of one of England's greatest physicians [Graves].

" 'The empire of reason, extending from the old to the new world, from Europe to the antipodes, has encircled the earth; the sun never sets on her dominions—individuals must rest, but the collective intelligence of the species never sleeps.' "

STEWART R. ROBERTS, S.M., M.D., Atlanta, Ga.
Major, M. R. C.

Relations Between Cancer and Diabetes.—An exchange quotes an article by H. Strauss in the *Deutsche medizinische Wochenschrift*, No. 39, to the effect that among 140 diabetic patients he found a history of cancer in the mother in sixteen and in the father in three. This seems to suggest, he says, that cancer in the parents predisposes to diabetes.

Medical Education and State Boards of Registration

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 8. Chairman, Dr. S. W. Welch, Montgomery.

COLORADO: Denver, Jan. 8. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

DISTRICT OF COLUMBIA: Washington, Jan. 8. Sec., Dr. Edgar P. Copeland, The Rockingham, Washington.

HAWAII: Honolulu, Jan. 10-13. Sec., Dr. G. A. Batten, Box 375, Honolulu.

INDIANA: Indianapolis, Jan. 8-10. Sec., Dr. W. T. Gott, 84 State House, Indianapolis.

MINNESOTA: St. Paul, Jan. 2-4. Sec., Dr. Thomas McDavitt, 741 Lowry Bldg., St. Paul.

NATIONAL BOARD OF MEDICAL EXAMINERS: New York City, Jan. 9-17. Sec., Dr. J. S. Rodman, 310 Real Estate Bldg., Broad and Chestnut Sts., Philadelphia.

NEW MEXICO: Sante Fe, Jan. 14. Sec., Dr. R. K. McClanahan, East Las Vegas.

NEW YORK: Albany, Buffalo, New York City and Syracuse, Jan. 29-Feb. 1. Sec., Dr. W. J. Denno, Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, Jan. 1. Sec., Dr. G. M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, Jan. 8-9. Sec., Dr. J. J. Williams, Weatherford.

OREGON: Portland, Jan. 1. Sec., Dr. Herbert S. Nichols, Portland.

PENNSYLVANIA: Philadelphia, Jan. 8-10. Sec., Nathan C. Schaeffer, State Capitol, Harrisburg.

RHODE ISLAND: Providence, Jan. 3. Sec., Dr. B. U. Richards, State House, Providence.

SOUTH DAKOTA: Pierre, Jan. 8. Sec., Dr. P. B. Jenkins, Waubay.

UTAH: Salt Lake City, Jan. 7-8. Cor. Sec., Dr. G. F. Harding, 407 Templeton Bldg., Salt Lake City.

WASHINGTON: Spokane, Jan. 1. Sec., Dr. C. N. Suttner, Baker Bldg., Walla Walla.

WISCONSIN: Madison, Jan. 14. Sec., Dr. J. M. Dodd, 220 E. Second St., Ashland.

WYOMING: Laramie, Feb. 6-8. Sec., Dr. H. E. McCallum, Laramie.

Minnesota August and October Examinations

Dr. Thomas McDavitt, secretary of the Minnesota State Board of Medical Examiners, reports the oral, practical and written examinations held at Minneapolis, Aug. 22-24 and Oct. 2-4, 1917. The examinations covered 18 subjects and included 80 questions. An average of 75 per cent. was required to pass. Eleven candidates were examined, all of whom passed. Eight candidates were licensed through reciprocity. The following colleges were represented:

College PASSED	Year Grad.	Per Cent.
College of Physicians and Surgeons, Chicago	(1896)	76
Indiana University	(1917)	87
Johns Hopkins University	(1914) 89; (1916) 88, 93; (1917)	84, 88
Harvard University	(1913) 90; (1917)	88
University of Michigan Medical School	(1904)	78
University of Minnesota	(1918*)	85

College LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
College of Physicians and Surgeons, Chicago	(1900)	Iowa
Hahnemann Medical Coll. and Hospital of Chicago	(1906)	Illinois
Northwestern University	(1914)	S. Dakota
Tulane University of Louisiana	(1910)	Louisiana
St. Louis University	(1915)	Missouri
Cincinnati College of Medicine and Surgery	(1877)	Ohio
Marquette University	(1915,2)	Wisconsin

* A year's internship in an approved hospital is required for graduation from the University of Minnesota Medical School, but only completion of a four-year medical course is required for licensure in Minnesota.

North Dakota July Examination

Dr. G. M. Williamson, secretary of the North Dakota State Board of Medical Examiners, reports the oral, practical and written examination held at Grand Forks, July 3-6, 1917. The examination covered 13 subjects and included 110 questions. An average of 75 per cent. was required to pass. Of the 3 candidates examined, 2 passed and 1 failed. Seven candidates were licensed through reciprocity. The following colleges were represented:

College PASSED	Year Grad.	Per Cent.
Chicago College of Medicine and Surgery	(1916)	77.5
University of Minnesota	(1916)	80.5
FAILED		
University of Michigan Medical School	(1911)	68.8

College LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
Bennett Medical College	(1910)	Nebraska; (1912) Illinois
Rush Medical College	(1886)	Indiana

University of Michigan Medical School	(1911)	Michigan
Minneapolis College of Physicians and Surgeons	(1911)	Minnesota
University of Minnesota	(1914)	Minnesota
St. Louis University	(1915)	Minnesota

Book Notices

Elements of Field Hygiene and Sanitation. By Joseph H. Ford, B.S., A.M., M.D., Colonel, Medical Corps, U. S. Army. Approved for Publication by the Surgeon-General, U. S. Army. Cloth. Price, $1.25 net. Pp. 248, with 152 illustrations. Philadelphia: P. Blakiston's Son & Co., 1917.

This manual, which is one of the many approved for publication by the Surgeon-General, concerns the principles involved in keeping troops healthy. After a brief introductory chapter, the author discusses personal hygiene, the march, camps, water, the mess, camp diseases, and illustrative regulations. The section on personal hygiene is modern in its point of view, giving special attention, as do all of the chapters, to the experiences of Pershing's expedition into Mexico and of the warring nations abroad in the present war. Perhaps a little too much space is devoted to the numerous methods for getting rid of lice, some six or eight methods being described, which would seem to indicate that none is satisfactory. The section devoted to the march is quite brief, but every sentence is practical and important. The most extensive portion of the book is that devoted to the camp. This is fully illustrated by pictures and diagrams of actual camps in various expeditions, and it takes up questions of choice of camp sites, shelter, disposal of waste, care of foodstuffs, bathing facilities, latrines, incinerators, etc. The chapter on camp diseases is also brief but accurate and practical. The book is based largely on methods practiced in our own Army, and frequent reference is made to special orders and regulations that have been issued at various times by the Surgeon-General's Office. The officer who studies this book and supplements his knowledge by securing the regulations referred to will find himself excellently equipped for rendering his duties satisfactorily.

Diseases of the Chest and the Principles of Physical Diagnosis. By George William Norris, A.B., M.D., Assistant Professor of Medicine in the University of Pennsylvania, and Henry R. M. Landis, A.B., M.D., Assistant Professor of Medicine in the University of Pennsylvania. With a Chapter on the Electrocardiograph in Heart Disease by Edward B. Krumbhaar, Ph.D., M.D., Assistant Professor of Research Medicine in the University of Pennsylvania. Cloth. Price, $7 net. Pp. 782, with 413 illustrations. Philadelphia: W. B. Saunders Company, 1917.

In the first 250 pages, the examination of the lungs and the examination of the circulatory system are considered. The principles underlying physical examination are especially emphasized. Technic and interpretation of signs are also clearly set forth. The third part (pp. 257-759) is taken up with the clinical features of chest diseases. The topics are treated briefly, with emphasis laid on physical signs and the underlying morbid anatomy. The subject of treatment is omitted. The especial feature of the work is the stress placed on the principles underlying physical diagnosis. To this end diagrams, drawings and photographs illustrating normal and pathologic anatomy are fully utilized. Most of these are of surpassing excellence. Those of frozen sections are wonderfully instructive, and if carefully studied will be of material help to student or practitioner in clearing up the meaning of physical signs that otherwise he might accept solely on authority. Krumbhaar has a brief but good chapter on the electrocardiograph. We might wish that the roentgen ray as a means of diagnosis had received a little fuller consideration. And we wish that some one would explain why the unclosed septum of the ventricles in congenital heart disease is so often called "imperforate," as it is by our authors. Are we wrong in thinking it is a plain misuse of the term? One might question the advisability of making a classroom textbook of this work for beginners in the study of physical diagnosis. But for the more advanced student, the hospital intern, or the practitioner who desires to perfect himself in this art, it should be a most stimulating and helpful book.

Medicolegal

Cannot Pay Experts for Examining Defendants

(*State vs. Weeks* (*N. H.*), *101 Atl. R. 35*)

The Supreme Court of New Hampshire, in overruling exceptions to an order disallowing a claim against the county for the fees of experts employed to examine the defendant, who was indicted for murder and the defense of insanity suggested, says that the case appeared to be one of new impression. No precedent has been found for the course here urged in behalf of the defendant; the proposition being that the public should pay the expenses incurred by the defendant outside of court in the preparation of his defense. Of course there can be no common-law authority for such an order. It required legislative action to give the defendant the rights he would have in a civil cause. It is manifest that a right so acquired cannot be extended so as to include a privilege or right never known to the common law, and in no way created by any statute. The statute governing the rights of persons charged with the more serious crimes was revised in 1901, and again amended in 1907. The subject has evidently received careful legislative consideration, and there is nothing in any of the statutes which have been enacted which gives color to the idea that authority has been conferred to charge the public with the expenses incurred by the defendant in preparing for trial, except so far as counsel fees and those for travel and attendance of witnesses are concerned. It was urged by the state in argument that the statute providing that "all legal costs attending the arrest, examination, or conveyance of an offender, except when directed or approved in writing by the counsel of the state, or county commissioners, shall be paid by the complainant" was applicable to this claim, and that it must be disallowed because its incurrence had not been previously authorized by the state's counsel. But that statute has no application to the claim here presented. It relates solely to expenses incurred in prosecutions for alleged crimes, and has nothing to do with the regulation of allowances to or on behalf of defendants. The state's contention that the court has no power to allow this claim is sound. But the reason for this result is that no such authority has been conferred on the court, and not that the consent of the state's counsel is essential.

Misbranding of a "Remedy"

(*Simpson vs. United States* (*U. S.*), *241 Fed. R. 841*)

The United States Circuit Court of Appeals, Sixth Circuit, affirms a conviction of defendant Simpson of violating the Food and Drugs Act as amended in 1912 by the interstate shipment of certain drugs alleged to have been misbranded in that the label of the carton or package containing the drug, as well as a circular therein, contained false and fraudulent statements regarding the curative or therapeutic effect of the drugs. The court says, among other things, that the information charged that the shipment was made by the defendant "trading as Dr. C. M. Simpson's Medical Institute," and that the name of the article given on the label of the carton was "Dr. C. M. Simpson's Cerebro-Spinal Nerve Compound." The natural construction would be that it was the defendant whose knowledge and reckless and wanton disregard of the truth was intended to be charged. The court also thinks the information should fairly be interpreted to mean that the misrepresentations were intended to accompany the bottles into the hands of the consumers. It alleged that the shipment consisted of "certain packages," and that the packages contained the circular or pamphlet later described therein; that one of the alleged misrepresentations appeared "on the label of the carton aforesaid," and that the other was "included in the circular or pamphlet aforesaid." It is matter of common knowledge that proprietary medicines in bottles are usually sold to the consumer in cartons, and that the latter usually contain circulars or other advertising matter. The court was not impressed with the suggestion

that the circular was charged to have been inside "the article of drugs."

The defendant's compound was not only represented generally to be a valuable remedy for the treatment of all diseases "resulting from diseases of the brain, spinal cord and medulla oblongata, and the nerves given off from each," "a remarkable discovery for the treatment of all nervous diseases," but also a "remarkable discovery for heart troubles," as well as a "most valuable remedy for nervous prostration, mania, melancholia and neurasthenia." There was substantial testimony from competent medical witnesses that there is no remedy applicable to all the diseases mentioned; that medical science and medical experience furnish no support for the broad claims made for the defendant's remedy; that "there is no one medicine that will prove a valuable remedy for all" the diseases enumerated. There was further substantial testimony from competent witnesses that bromids, which constitute a prominent ingredient in the defendant's remedy, are sedative in their nature and, in ordinary doses, not stimulating; that while thus helpful in quieting an exalted or excited state of the nerves, as in many cases, including some cases of mania, they are not only not helpful, but are positively injurious, in depressed conditions, as in melancholia; that there is no one remedy for all spinal diseases, or for all cases of neurasthenia, or heart trouble, or for all cases of melancholia or of mania; that some diseases of the heart require sedatives, others stimulants, etc.; that the defendant's compound was dangerous to intrust to the hands of a layman. The defendant's proposition that the presence of ammonium carbonate neutralized the effect of the bromids as depressants was denied by medical witnesses for the government. True, it appeared that bromids are beneficial, at least as a palliative in quieting the nerves and inducing sleep, in ordinary cases of nervous excitability, and there was testimony on the part of the defense that several persons had received benefit, indeed, many of them claimed to have been cured, by the use of the defendant's remedy; but such testimony, at the most, bore only on the question of fact whether the alleged representations were, as made, false and fraudulent. There was still room for a conclusion that substantial mischief resided in the claim of a universally efficacious remedy for the numerous and widely prevalent maladies in question; for the term "remedy" must at least imply a curative tendency, although not, of course, guaranteeing a cure.

Society Proceedings

COMING MEETINGS

American Association of Anatomists, Minneapolis, Dec. 27-29.
American Physiological Society, Minneapolis, Dec. 27-29.
Society of American Bacteriologists, Washington, D. C., Dec. 27-29.

SOUTHERN MEDICAL ASSOCIATION

Eleventh Annual Meeting, held at Memphis, Tenn., Nov. 12-15, 1917

(*Concluded from page 2144*)

The Normal College as a Factor in the Dissemination of Public Health Knowledge in the South

DR. U. F. JONES, Hattiesburg, Miss.: The normal schools are among the few largest factors in the educational scheme of this country. The normal school is not doing justice in training its teachers in health work unless it has a clinic for the diagnosis of such defects as they will constantly find in their own schoolrooms.

Oral Sepsis and the Anemias

DR. M. L. GRAVES, Galveston, Texas: Anemia constitutes but one of the numerous clinical manifestations of sepsis or infection, whether it originates in the mouth or elsewhere. It is a fairly constant symptom in all the grave infections, and to a more moderate extent in the less severe ones. Sufficient is known at present to entitle us to more than a suspicion that William Hunter was correct in believing that pernicious or infective anemia should be laid at the door of mouth infection. In one case, infected teeth were removed; the patient made such rapid and marked improvement that he has resumed a laborious occupation, with the appearance of health and a blood exhibit approximating the normal. Cases of secondary anemia, associated with arthritic disease, have responded but poorly to blood tonics, such as iron. One case, in a recent experience, responded rapidly to an autogenous vaccine made from the removed tonsils containing abscesses, and the symptoms have improved in a notable way, while resistant to all other treatments, including antistreptococcic serums and stock vaccines. These experiences have led me to the belief that mouth infections are frequently the cause of acute and chronic illnesses, with or without anemia, and to the insistence that every focus of infection be removed in the effort to restore health.

Oral Sepsis and Arthritis

DR. J. HEYWARD GIBBES, Columbia, S. C.: A proper investigation of the gingivae, teeth and alveolar processes must include roentgenographic studies. The important relationship of chronic pyogenic infections to a large group of the arthropathies has been conclusively demonstrated, and the first step in the management of these cases should consist in a systematic search for foci of infection. No one portal of entry for infecting micro-organisms should be allowed to obscure the importance of investigating all possible sources of infection.

Oral Sepsis and the Cardiovascular System

DR. ALEXANDER G. BROWN, Richmond, Va.: Focal infection of the mouth, chronic alveolar abscess, chronic pericementitis, acute and chronic infection of tonsils and other oral, nasal and other cavities adjacent, produce serious, grievous and dangerous diseases of the heart, endocarditis, myocarditis, pericarditis and pancarditis.

Relation of Oral Sepsis to the Nervous System

DR. E. BATES BLOCK, Atlanta, Ga.: I have under my care several epilepsy patients in whom pyorrhea alveolaris or apical abscesses existed, and no other cause for epilepsy could be found after carrying out the usual methods of investigation. In view of the abscence of other discoverable causes and the results obtained, I was inclined to think these cases due to this focal infection.

Relation of Chronic Infection to Thyroid Deficiency

DR. HARVEY G. BECK, Baltimore: Glandular insufficiency is of common occurrence, and is frequently overlooked. Chronic infections are almost invariably associated with glandular syndromes. These infections are usually focal in character, and seem to occur with the same relative frequency in insufficiency of the thyroid, pituitary, gonads and suprarenal. Rheumatism shows a special tendency to involvement of the thyroid. In seventy-eight of the 100 cases in my series at the time of examination, the patients suffered with chronic infections, mostly focal in character; ninety-four either showed evidence or gave a history of infection antedating the onset of symptoms. In several instances, well marked symptoms of thyroid deficiency developed after protracted acute fevers. Symptoms appeared in two cases following typhoid; one, malaria; one, puerperal infection, and one, repeated attacks of rheumatic fever. Oral sepsis and inflammatory diseases of the gallbladder and appendix play an important part in the relation of chronic focal disease and hypothyroidism, comprising 63 per cent. of the 255 infections present in the series. The remaining 37 per cent. form a miscellaneous group, and include among others pelvic infection, pyelitis, arthritis, amebic dysentery, anal fistula, syphilis and tuberculosis. Oral sepsis embracing tonsillitis, root abscesses, pyorrhea, sinusitis, etc., represents 36 per cent. of the total infections, and occurred in fifty-six of the cases. Chronic appendicitis was observed in thirty-two cases, and cholecystitis and cholelithiasis in twenty-four. In several instances, symptoms of both appendicitis and cholecystitis existed in the same individual.

The Wild Rats of the Southern States as Carriers of Spirochaeta Icterohemorrhagiae

DRS. JAMES W. JOBLING and A. A. EGGSTEIN, Nashville, Tenn.: Published in THE JOURNAL, Nov. 24, 1917, p. 1787.

Classification and Treatment of the Acute Diarrheal Diseases in Infancy

DR. JOHN L. MORSE, Boston: Diarrhea from an excess of fat in an artificial food is not at all uncommon. When the disturbance is a mild one, the stools are not much changed in color, but contain many small, soft curds and some mucus, and are somewhat more acid in odor and reaction than usual. Sometimes they are gray and shiny, and in other instances, when there is an excess of neutral fat, they are creamy in consistency and color. Sometimes they look like curdled milk. In other instances they are bright yellow and have an oily appearance. They are seldom green, unless there is also a disturbance in the digestion of sugar. In the worst cases, they are watery, strongly acid, and cause marked irritation of the buttocks. When this happens, the fat is in combination with the alkaline salts, especially sodium. As the result, there is a considerable loss of alkaline salts in the stools. A relative acidosis is thus produced, with an excess of ammonia in the urine. The symptoms of acid intoxication may then develop. A high fever is not uncommon in these severe cases. The prognosis depends on the severity of the symptoms, but is in general good, unless there is a marked acid intoxication. The treatment consists in the complete elimination of fat from the food. In most instances it is advisable to give a cathartic in the beginning, and to starve for from twelve to twenty-four hours. In the cases with acid intoxication, sodium bicarbonate should be given in some way and a food containing considerable amounts of sugar, preferably in the form of glucose or maltose. In the less severe cases, protein is usually well tolerated; and the caloric value of the food, which is much reduced by the withdrawal of the fat, can be made up by increasing the amount of carbohydrates. Fat can usually be cautiously added again in a few days. How rapidly it can be added can be determined only by observation of the symptoms, and examination of the stools.

Diarrhea is more often due to an excessive protein in human milk than to an excess of either fat or lactose. The protein is most likely to be excessive in the early days of lactation, and at the time of menstruation. An excess of protein may also be due to excitement, anxiety and nervousness, or to fatigue or lack of exercise. The diarrhea is usually not serious. The baby is ordinarily not very sick, and the temperature is but little, if at all, elevated. The stools are loose or watery, and often contain fat curds as the result of the increased peristalsis and the consequent interference with absorption. The stools are usually brownish yellow, but may be green. They often contain mucus. The odor is not characteristic; the reaction is alkaline or feebly acid. They are not irritating to the skin.

The most important element in the treatment of infectious diarrhea is the diet. The character of the diet depends on the variety of the micro-organism that is causing the disease. These micro-organisms can be divided, as far as the determination of the diet to be used is concerned, into two groups: (1) the various forms of the dysentery bacillus and the other organisms, except the gas bacillus, which cause the disease, and (2) the gas bacillus and allied organisms. The other organisms, although of many different varieties, are grouped with the dysentery bacilli, because as regards their growth and the production of toxic substances from protein and carbohydrate mediums, they behave in the same way.

Malaria in Infants

DR. MORGAN SMITH, Little Rock, Ark.: Malarial infection is less frequent in the infant than in the child or adult, because of the vigilance on the part of the mother to protect her baby from the bites of all insects. The treatment of malaria in the infant does not differ from that employed in the child or the adult.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Diseases of Children, Chicago

December, XIV, No. 6

1 *Diagnosis of Age of Fetus by Roentgenograms. J. H. Hess, Chicago.—p. 397.
2 *Internal Hydrocephalus. W. E. Dandy and K. D. Blackfan, Baltimore.—p. 424.
3 *Survey of Juvenile Delinquents. H. K. Faber and A. J. Ritter, San Francisco.—p. 444.
4 *Cause of Sudden Death in Status Lymphaticus. D. Symmers, New York.—p. 463.
5 Treatment of Eight Cases of Secondary Anemia in Infants by Blood Transfusion. C. G. Kerley, New York.—p. 470.

1. **Roentgenograms and Age of Fetus.**—Hess is convinced that the roentgenographic method of determining the age of the fetus is more reliable than determination of age based on length and other measurements, since osseous development is more regular and offers many more factors for consideration. In the early months more accurate determination is possible than in the later months.

2. **Internal Hydrocephalus.**—Twenty-six cases of internal hydrocephalus were studied by Dandy and Blackfan, fifteen of the obstructive and eleven of the communicating variety, by means of intraventricular and intraspinal injections of phenolsulphonephthalein.

Postmortem examinations demonstrated an obstruction in every case in which an obstruction had been shown clinically by this test. The obstruction may be a congenital malformation or inflammatory process or tumor, and occur at any part of the ventricular system, but usually at the aqueduct of Sylvius or the foramina of Luschka and Magendie. Hydrocephalus results because the fluid is mechanically prevented from passing from the ventricles, where the fluid forms, to the subarachnoid space, where it is normally absorbed, and where only it can be absorbed. Obstructive and communicating hydrocephalus are essentially the same, and in reality all are due to obstruction. In the obstructive variety the obstruction is in the ventricular system; in the communicating variety the obstruction is in the subarachnoid space. Obstructive hydrocephalus may, by operation or spontaneously, change to communicating hydrocephalus, or the reverse may occur spontaneously. Careful studies with the phenolsulphonephthalein test will indicate these possibilities. The authors are convinced that the surgical treatment of internal hydrocephalus has now a definite anatomic basis and hopeful prospects.

3. **Juvenile Delinquents.**—Faber and Ritter's survey is of 110 juvenile offenders. The physical findings are, on the whole, those of neglected hygiene, secondary in most cases to poverty. The mental findings show that of the boys studied 43.6 per cent. were normal, 25.5 per cent. dull normal, 17 per cent. borderline, 9.6 per cent. morons, and 4.3 per cent. imbeciles. The authors believe that for the normal boys improved environment, improved personal hygiene, and better general education would have made useful citizenship possible. The first indication is obviously to separate the normals and dull normals from the rest, to keep the borderline cases under observation, with careful and systematic attempts to education in order to determine and develop latent ability; and finally to segregate promptly those who are beyond question feebleminded. The authors prefer the Yerkes-Bridges-Point Scale to the Binet-Simon tests. They claim greater accuracy for the former.

4. **Sudden Death in Status Lymphaticus.**—Symmers says that among the first 4,000 necropsies at Bellevue Hospital, status lymphaticus was encountered in 249 subjects, or in 6.2 per cent.; 118 examples of status lymphaticus were encountered; 89 cases belonged to the recessive type; 42 were borderline cases. Of the 118 cases of straightforward status lymphaticus, the thymus was enlarged in every case. The faucial tonsils were enlarged 61 times; the lingual tonsils 58 times; the pharyngeal lymphoid follicles 45 times; Peyer's patches and the solitary follicles 105 times; axillary nodes 11 times;

inguinal nodes 12 times, and the cervical nodes 15 times. The spleen was small or normal in size in 68 cases; the malpighian follicles were hyperplastic 101 times. Of 89 cases of recessive status lymphaticus the thymus was weighable 19 times, and the average was 18 gm. In the remaining 70 cases the thymus was completely replaced by fat. The faucial tonsils were hyperplastic 25 times; the lingual tonsils 32 times, and the pharyngeal tonsils 19 times. Peyer's patches were atrophied 61 times; solitary follicles 37 times. The splenic follicles were enlarged 37 times and atrophied 39 times. The spleen was normal or small in size in 52 cases (71 per cent.).

According to Symmers, sudden death in status lymphaticus may be occasioned, first, by an anaphylactic reaction due to sensitization of the body by a specific nucleoprotein formed in the lymph nodes as the result of necrosis of numbers of germinal follicles. Before the so-called anaphylactic incubation period has expired the tissues are again subjected to the action of the same protein formed in the same type of tissue in response to an apparently trivial injury, and, in this way, the anaphylactic reaction is completed. Second, spontaneous rupture of an hypoplastic cerebral vessel, or rupture following apparently trivial injury, the deficiency in the vessel wall being most noticeable in the muscular coat.

Boston Medical and Surgical Journal

December 6, CLXXVII, No. 23

6 *Radioactive Substances in Treatment of Malignant Disease. W. Duane, Boston.—p. 787.
7 Orthoarteriotony (New Form of Pharmacodynamic Energy). C. J. Enebuske, Sater, Sweden.—p. 799.
8 *Tendon Suture. T. W. Harmer, Boston.—p. 808.
9 *Testing and Recording Vasomotor Reflexes of Skin. E. A. Tracy, Boston.—p. 810.
10 Speech Correction—New Medical Study and Educational Movement. W. B. Swift, Boston.—p. 811.

6. **Radioactive Substances in Treatment of Malignant Disease.**—Over 500 new cases of malignant disease a year are seen at the Huntington Hospital, almost all of which receive treatment with radioactive substances. In some cases, very satisfactory results have been obtained, giving what may be called apparent cures. In others, marked alleviation has been observed, with prolongation of life and increased comfort; and in other cases still, no benefit, and possibly added discomfort, may have been produced. Duane's paper contains a detailed statement of methods employed in preparing the radioactive substances, of the methods of measuring the dosage, and of the general principles on which the character of the treatment is determined; a description of the scientific principles employed in the preparation of the applicators and of the instruments for measuring their radioactivity, and a brief statement of the kinds of cases in which the various methods are used and the dosages actually employed.

8. **Tendon Suture.**—Harmer uses silk and overcasts the lateral margins of both ends of a divided tendon. The overcasting starts about the width of the tendon or a little more back from the point of division, and comprises several whippings about the side of the tendon down to the line of division, each loop including somewhat less than one-quarter of the circumference of the tendon. When a tendon is ready to be brought together, each end then carries two stitches and each stitch two ends. The two parts of the tendon are now brought together and the two suture-ends nearest the line of division on one side are tied. The two pairs of stitch-ends on the other side are then similarly tied. The long ends so tied alongside the tendon seem to serve as lateral splints.

9. **Method of Testing Vasomotor Reflexes of Skin.**—In a normal person, when the skin is lightly stroked (with a pressure of about 2 ounces) there appears on the stroked surface a brief deepening of the skin tint lasting up to eight or twelve seconds, and then a white streak appears that lasts for a couple of minutes. The blood vessels in the stroked area dilate and then contract. In each case tested four tests are made: 1. The skin of the left side of the face is stroked, and the length of time the reflex vasodilatation lasts and the time it takes the reflex vasoconstriction to appear is noted; this is done with the aid of a stop-watch. The length of time the vasoconstriction lasts is also noted. 2. The same is done for the right side of the face. 3. The left forearm, on the palmar surface, an inch or so from the wrist, is similarly stroked. The time the vasoconstriction appears and its duration are noted. 4. The same is done for the right forearm. A study of the reactions in normal and diseased individuals has led to important findings of use in diagnosis.

Cleveland Medical Journal

November, XVI, No. 11

11 Utilitarian Construction of Living Things and Medical Student. T. L. Patterson, Kingston, Canada.—p. 707.
12 Tracheal Displacement and Compression in Intrathoracic Disease. V. C. Rowland, Cleveland.—p. 715.
13 Spontaneous Explosion of Artificial Eyes. R. B. Metz, Cleveland.—p. 719.
14 Extracts from Paris' Pharmacologia. T. Sollmann, Cleveland.—p. 721.
15 Nitrous Oxid and Oxygen Analgesia in Operations on Ear, Nose and Throat. S. H. Large, Cleveland.—p. 725.

Florida Medical Association Journal, Jacksonville

November, IV, No. 5

16 Tuberculosis Problem. R. H. McGinnis, Jacksonville.—p. 127.
17 Electricity and Vibration in Gastro-Intestinal Affections. G. M. Niles, Atlanta, Ga.—p. 130.
18 Case of Maculo-Anesthetic Leprosy. J. L. K. Smith, Jacksonville.—p. 134.

Georgia Medical Association Journal, Augusta

November, VII, No. 7

19 Renal Surgery. E. G. Jones, Atlanta.—p. 131.

Journal of Nervous and Mental Disease, Lancaster, Pa.

November, XLVI, No. 5

20 *Three Cases of Chronic Progressive Lenticular Degeneration, with Mental Deterioration. J. J. Thomas, Boston.—p. 321.
21 Dispensary Work in Diseases of Nervous System. S. E. Jelliffe, New York.—p. 333.
22 *Brain Tumor in Case Clinically Considered to Be Paresis. L. G. Lowrey, Boston.—p. 347.
23 *Dilatation of Lateral Ventricles as Common Brain Lesion in Epilepsy. D. A. Thom, Palmer, Mass.—p. 355.

20. **Chronic Progressive Lenticular Degeneration.**—The cases reported by Thomas comprise three children in one family, similarly affected, thus showing the familial character of Wilson's disease, with no discoverable heredity. These cases differ in several essential points from those reported by Wilson, first in the character of the tremor, the absence of fixed spastic smile, the dysphagia, and especially in the evidence of the affection of the pyramidal tracts. There was also no evidence of any affection of the liver so far as could be determined. In some respects these cases much more closely resemble multiple sclerosis, yet there are various and important reasons for rejecting this view. First, the distinctly familial character of these cases with three children out of six in one family affected, and a fourth probably beginning to show the characteristic signs, which are so similar that even the parents now have grown to expect the appearance of the symptoms as the children approach the age of 8 years. Then the absence of nystagmus and changes in the eyegrounds, and the steady progressiveness of the disease, the absence of remissions in the symptoms, and most important of all, the mental deterioration must be considered. These cases resemble those described under the title of pseudosclerosis. They showed no pigmentation of the skin or cornea, no epileptiform attacks, no enlargement or diminution in size of the liver, and were distinctly familial in character.

22. **Brain Tumor Clinically Considered to Be Paresis.**—Lowrey presents a study of a case of glioma involving the third and posterior portion of the lateral ventricles and the corpus callosum. The case was diagnosed as paresis but no evidence of paresis was found in the microscopic study of the cortex.

23. **Dilatation of Lateral Ventricles as Brain Lesion in Epilepsy.**—Since January, 1913, Thom has collected the brains of 75 epileptic subjects, the results of 82 consecutive postmortem examinations; 57 of this group presented gross brain lesions; 31 of these 57 cases presented cortical lesions as well as dilated ventricles; 16 showed lesions of the cortex alone, while the remaining 14, with a normal looking cortex, had dilated lateral ventricles. Of the entire 43 cases reveal-

ing cortical lesions, the hind portion of the brain was by far the most frequently affected, especially the occipital lobes. The convolutional shrinkage in this region was often marked, and the appearance was that of an acquired condition rather than one of congenital origin. Next in order of frequency was the general cerebral gliosis, where the entire cerebrum appeared to be involved. Softenings were noted only six times, once being general, the other five times being focalized. There were 29 cases of well defined sclerosis of the basilar and cerebral vessels. Gliosis and atrophy of one hemisphere alone was noted in 8 cases, equally divided between the two hemispheres. In the dilated ventricle group were 41 cases; 27 of the brains in this group also had abnormalities of the cortex. The remaining 14 cases with dilated ventricles, where the cortex of the brain was not grossly abnormal but where the ventricular dilatation was of such a degree as to leave no doubt of its abnormality, raises the question in Thom's mind as to whether lesions affecting primarily the white matter may not be a factor in the production of epilepsy.

Southwestern Medicine, El Paso, Texas

November, I, No. 11

24 Medical Supervision of Industrial Employees. G. H. Fitzgerald, Bisbee, Ariz.—p. 12.
25 Pellagra. W. Howe, Las Vegas, N. M.—p. 15.
26 Treatment of Acute Bronchopneumonia in Children. C. A. Reinemund, El Paso.—p. 21.
27 Vital Statistics. C. Wilbur.—p. 26.
28 Tuberculosis and Asthma. O. H. Brown, Phoenix, Ariz.—p. 31.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

Dublin Journal of Medical Science

August, CXLIV, No. 548

1 Conservation of Youth. E. Wooton.—p. 73.
2 Maternity and Child Welfare in Dublin County Borough. E. G. A. Webb.—p. 86.
3 Case of Melena and Hematemesis Neonatorum. B. Solomons.—p. 97.

September, No. 549

4 Summary of Surgical Technic in Nerve Lesions of Modern Warfare. C. G. Cumston.—p. 137.
5 Wassermann Test as Means of Estimating Prevalence of Syphilis in Community. G. R. Darling.—p. 147.
6 *Pathologic Report of Rotunda Hospital for Two Years Ending Oct. 31, 1916. R. J. Rowlette.—p. 152.

October, No. 550

7 Shell Shock. F. C. Purser.—p. 201.
8 Early Diagnosis of Venereal Disease and Laboratory Aids to Successful Treatment. J. McCullagh.—p. 212.

6. **Pathologic Report of Rotunda Hospital.**—Rowlette's report covers a period of two years, from Nov. 1, 1914, to Oct. 31, 1916. Curettings and other fragments removed for purposes of diagnosis were examined on 222 occasions. One case of tuberculous endometritis was encountered, associated with tuberculosis of the tubes. The great majority of curettings (114 out of 138) showed definite glandular changes, varying from moderate increase in number to considerable hypertrophy, with invagination of epithelium, and in eighteen cases, formation of cysts. Twenty-two cases of malignant disease of the uterus were dealt with by operation. Of these cases, fifteen were epithelioma of the cervix, and one adenocarcinoma of the cervix, three adenocarcinoma of the body, two sarcoma of the body, and one chorionepithelioma. Sixty-three cases of myoma were examined. In twenty-six secondary changes other than fibrosis, which is almost always present, had occurred. Of forty-one cases of salpingitis examined, only seven were tuberculous. Of forty-eight cysts of the ovary, four were dermoids, eight syphilitic cysts, twenty-four smooth walled cystadenoma, and thirteen papillary cysts, eight of which gave histologic evidence of malignancy. Three solid tumors of the ovary came under examination, of which number two were carcinomas, and the other was a fibroma.

Journal of Tropical Medicine and Hygiene, London

November 1, XX, No. 21

9 Some Peculiar Bodies in Blood of Certain African Snakes. J. E. L. Johnston.—p. 241.
10 Etiology of Craw-Craw (Nodular Dermatitis). A. Pijper.—p. 242.

November 15, No. 22

11 Two Unusual Cases of Filariasis in North Queensland. A. Breinl and H. Priestley.—p. 253.
12 Value of Salvarsan in Relapsing Fever and Malaria. W. L. Peacock.—p. 254.

Lancet, London

November 17, II, No. 4916

13 Value and Limitations of Sanatorium Treatment. T. D. Lister.—p. 739.
14 *Tartar Emetic in Treatment of Malaria. A. W. Falconer and A. G. Anderson.—p. 743.
15 *Mortality from Postcholeraic Uremia. L. Rogers.—p. 745.
16 Epitheliomatous Neoplasms of Dorsal Aspect of Hand. C. G. Cumston.—p. 746.
17 Case of Twin Pregnancy with One Macerated Fetus. J. B. Hellier.—p. 748.
18 Case of Congenital Angioma of Tongue. F. M. Hughes.—p. 749.
19 Perfusion of Heart with Nicotin. D. T. Barry.—p. 759.

14. **Tartar Emetic in Treatment of Malaria.**—Eight cases were treated intravenously with tartar emetic. They include infections both with benign and malignant tertian parasites. The tartar emetic was used in a 2 per cent. solution, to which 0.5 per cent. phenol was added to preserve its sterility. Of these eight cases there were two mixed infections, one subtertian malaria and five benign tertian malaria, three of which showed gametocytes. Of the two mixed infections, the crescents disappeared in both cases, the benign tertian parasites persisting in one and disappearing in the other. In the subtertian crescent infections the crescents disappeared after three injections of tartar emetic. In spite of the disappearance of the crescents the patient had three typical clinical attacks of malaria, though the parasites could not be demonstrated again in the peripheral blood stream. Of the five benign tertian infections, in none did the parasites disappear from the blood stream till large doses of quinin had been administered. In the three patients in which gametocytes were seen, in two the gametocytes were not found subsequent to the tartar emetic treatment; in the other patient the gametocytes persisted. Neither in the subtertian cases, nor in the benign tertian cases, was any marked clinical improvement noted, and in the benign tertian cases the tartar emetic did not appear to exert any effect whatever on the parasites.

15. **Mortality from Postcholeraic Uremia.**—Rogers records a 70 per cent. reduction in the mortality through the intravenous injections of sodium bicarbonate. Two solutions are now used. The first is the hypertonic saline, which Rogers has given with much success in well over 1,000 cases during the last ten years. It consists of 120 grains of sodium chlorid with 4 grains of calcium chlorid to a pint of sterile water. For several years now Rogers has omitted the potassium chlorid of Ringer's fluid, as some physiologists regard this as an unnecessary and possibly depressant addition, and the increasingly favorable results obtained in recent years show that it is certainly not required. The second, or alkaline solution, contains 60 grains of sodium chlorid and 160 grains (2 per cent.) of sodium bicarbonate, and is thus also a hypertonic fluid. To avoid decomposition of the bicarbonate on boiling, the chlorid solution is sterilized before the bicarbonate is added, and the latter sterilized in packets in an autoclave and subsequently added.

In patients admitted early without prolonged suppression of urine the hypertonic sodium chlorid solution only is used at the first transfusion, the quantity being regulated by the specific gravity of the blood. If the case is sufficiently severe to require further intravenous injections, at each subsequent transfusion 1 pint of the alkaline solution is first given and followed by the hypertonic chlorid solution in the quantity indicated by the specific gravity of the blood. In patients admitted late with suppression of urine for twelve hours or more the alkaline solution is given at the first injection as well. Moreover, it is used in all cholera patients with deficient urinary secretion without much concentration of the blood as shown by the specific gravity, in which the normal saline was formerly advised by Rogers. As long as the specific gravity of the blood is not much below the normal, such as not less than 1,050, a pint of the alkaline solution can always be safely given intravenously for deficient secretion of urine. In addition, this solution is now used in the place of normal saline by the bowel when formerly advised.

Archives des Maladies de l'Appareil Digestif, etc., Paris

September, IX, No. 6, pp. 297-360

20 Mathieu and the Pathology of the Digestive Apparatus. J. C. Roux.—p. 297.
21 *Hypertrophic Stenosis of the Pylorus in Adult. L. Urrutia. p. 333.
22 *Dyspepsia After Loss of Teeth. A. Mollière.—p. 337.
23 *Stomach Disturbances in the Gassed. E. Agasse-Lafont and J. C. Roux.—p. 341.

21. **Stenosis of the Hypertrophied Pylorus in Adult.**—The woman of 43 had eight children and had always been well until the last year. The assumption of cancer at the pylorus was sustained by occult blood in the stools. Several ascarides were found at the resection operation but nothing to suggest malignant disease. Urrutia believes that the helminthiasis must have been responsible for the occult blood.

22. **Dyspepsia after Loss of Teeth.**—Mollière provides at the regiment infirmary a special diet for men without teeth. It is planned so it will not hurt the gums and yet will keep up the habit of mastication. The vegetables, etc., are cooked extra thoroughly but are not mashed. The meat is given in the form of meat juice or finely chopped meat. As men with defective or no teeth do not masticate normally, there is not the normal stimulus for secretion of saliva. To remedy this he adds condiments in moderate amounts to the food: pepper, salt, thyme, laurel and onions.

23. **Injury of the Stomach in the Gassed.**—Lafont and Roux give the details of five cases in which gassed soldiers suffered from the stomach the next day, vomiting after each meal for several days and then developing all the symptoms of gastric erosion or ulcer. One man vomited blood on two occasions. Another had melena and the erosion seemed to be in the duodenum. Gastro-enterostomy was done in this case and all symptoms subsided. No operation was attempted in the other cases, and only partial improvement has been noted to date under strict courses of treatment as for gastric ulcer. The gas was of the "weeping gas" type.

Archives de Médecine et de Pharmacie Militaires

March, LXVII, No. 3, pp. 309-452

24 *Flying Base Hospital. (Nouveau type de formation chirurgicale mobile.) L. Plisson.—p. 309.
25 Indications for Different Types of Artificial Legs. M. Séron. —p. 353.
26 *Identification of the Dead in War. L. Bosredon.—p. 369.

24. **Flying Base Hospital.**—Plisson's system of interchangeable automobile units to constitute a base hospital that can be enlarged or reduced at need and moved rapidly by its own power to points where it is needed at different times, was described recently in THE JOURNAL, page 1914. The complete details of equipment, etc., are described here, with illustrations.

26. **Identification Tags.**—Bosredon comments on the large number of "missing" in each of the belligerent armies. This testifies that the present methods of identification of the dead have not proved efficient. He describes the various methods that have been adopted and some that have been discarded. In Italy, since 1915, the soldiers have been wearing a hinged metal tag that contains a folded paper with full identification details. The two small sheets of metal thus form a case suspended by holes at the outer end. The Austrians use a similar double metal tag. Russian soldiers carry no provision for identification. The Belgian army insists on conveying all cadavers to the rear, each division having a morgue with special vehicle. This permits identification at leisure. Bosredon has devised a wrist tag and already thousands have been distributed to the soldiers. It consists of a small metal plate with name and other details stamped on it in duplicate, above and below, with a line of perforations between. This permits the lower half to be torn off for identification purposes, while leaving the other half permanently on the cadaver. It is fastened to the wrist with a light metal chain and rivet. The details regarded as indispensable are the name and the year of enrolment on one side of the tag; the number of the recruiting office and the number given the recruit are on the back of the tag. The tags already in use can be utilized by adding the wrist chain.

Paris Médical

November 3, VII, No. 44, pp. 353-388

27 Malaria in French Forces in Macedonia. P. Carnot.—p. 353; E. Marchoux.—p. 360.
28 Technic for Examination of Blood in Malaria.—L. Tribondeau. —p. 364.
29 *Initial Symptoms of Malaria. Mauban.—p. 368.
30 Technic for Giving Quinin in Malaria. C. Garin.—p. 373.
31 Arsenic in Malaria. P. Carnot.—p. 379.

November 10, No. 45, pp. 389-404

32 Cardiovascular Disturbances in the Gassed. J. Parisot and L. Tixier.—p. 389.
33 *Epidemic of Scurvy. P. Harvier.—p. 394.
34 Thorium Sulphate in Intestinal Infections. Fenestre and Gérard. —p. 398.
35 *Verrucous Lesions Simulating Verrucous Tuberculosis. H. Gougerot.—p. 399.

29. **Initial Symptoms of Malaria.**—This entire issue of the *Paris Médical* is devoted to diseases of exotic origin, malaria in particular. Mauban analyzes the findings in seventy-two cases of primary malaria in August in Macedonia, commenting especially on the sudden severe onset. The weakness was so extreme in all but one case that the men had to lie down where they were, too weak even to fire their gun to call attention to their sudden sickness. Bronchitis with spasmodic coughing was almost the rule, notwithstanding the warm weather, as an early manifestation of the malaria. In 75 per cent. of his cases the eyes were bloodshot and tender, in addition to the ordinary symptoms of malarial infection.

33. **Epidemic of Scurvy.**—Harvier describes the scurvy he has encountered in soldiers who have been unable to get any fresh vegetables for periods of from four to six months. He sought out the camp from which these men came, and found 184 excused from duty on account of "abscess," "lymphangitis," "rheumatism" or other diagnosis, but at a glance he recognized scurvy in all. Ranging the other men in two rows, he passed along inspecting the gums of each, and in almost 20 per cent. he found the gingivitis of scurvy. Fully 95 per cent. of the body of 817 men had had scurvy.

35. **Verrucous Nontuberculous Skin Lesions.**—The importance of the verrucous epidermitis which Gougerot describes lies in its deceptive resemblance to verrucous tuberculous affections. Only the absence of antecedents, the multiple onset and rapid development distinguish it at first, but it usually heals at once under treatment with dressings impregnated with a 1:30 solution of resorcin, followed by paste of yellow oxid of mercury.

Presse Médicale, Paris

October 18, XXV, No. 58, pp. 597-604

36 *Stiff Ankle. Ducroquet.—p. 597.
37 Treatment of Imported Malaria. A. Manaud.—p. 599.

October 22, No. 59, pp. 605-616

38 *Tachyphylaxis. H. Busquet.—p. 605.
39 Quadrant Hemianopsia and the Cortical Center for Vision. A. Monbrun.—p. 607.
40 Plantar Paralysis. L. Moreau.—p. 609.
41 Technic for Laminectomy. E. Girou.—p. 610.
42 *Urine Test for Typhoid. H. Diacono.—p. 611.

36. **Stiff Ankle.**—Ducroquet gives a profusely illustrated review of the disturbances in the gait with ankylosed ankle.

38. **Tachyphylaxis.**—This term was coined to express the rapid immunization conferred by injection of a small preliminary dose. The immunization is complete in a few minutes, so that injection then of a large amount does not have the action that it would have had if the preliminary small dose had not been injected. Busquet reports experimental research in this line. Attempting to apply the conclusions to man, he was unable to detect any immunizing action from a preliminary small dose of colloidal metals. In animals, the tachyphylaxis was marked with certain drugs used by intravenous injection in the clinic. It was also evident in man with sodium nucleinate, chaulmoogra oil and the arsenobenzenes. A small preparatory dose of either of these enabled a large dose, given a few minutes later, to be tolerated without the reaction inevitable otherwise. The data already acquired justify the application of this principle of an immunizing preliminary dose in transfusion of defibrinated blood in case of hemorrhage; also with intravenous injection of organ extracts in cases of glandular insufficiency.

42. **Diagnosis of Typhoid from the Urine.**—Diacono's test is based on determination of the precipito-agglutinable substances in the urine under the influence of typhoid antiserum. He uses a set of test tubes with 20 c.c. urine, one containing normal urine. To each tube is added from 0.1 to 0.5 c.c. or 1 c.c. of typhoid antiserum. After incubation at 37 C. for three or four hours, a flaky sediment is apparent in the positive cases while the control tube keeps clear. The urine must not be filtered. A trace of salt added to the urine hastens the precipitation.

Progrès Médical, Paris

November 3, XXXII, No. 44, pp. 369-376

43 *Protection for Soldier's Heart. Filderman and Bonnette.—p. 369.
44 Rapidly Fatal Addison's Disease in Course of Tuberculous Pleurisy. J. Tapie.—p. 371.

43. **Protecting Devices for the Soldier.**—Fildermann and Bonnette remark that the weight and clumsiness of a really protecting cuirass forbid its use to date, but that there is every reason for some light device to protect the heart. This is a peculiarly vulnerable region as there is no natural protection here, while the slightest wound of the heart may prove fatal. They suggest, until something better can be devised, to have a thin sheet of metal, about 2 mm. thick, sewed between the coat and its lining over the heart region. It could reach to the collar of the coat and lie just outside of the buttonholes. Suitable dimensions would be 15 cm. in height by 13 at the base, the part near the shoulder slanting from the neck outward, leaving the outer straight edge at the base only 6 cm. A sheet of metal of the kind need not weigh more than 250 gm.

Correspondenz-Blatt für Schweizer Aerzte, Basel

November 10, XLVII, No. 45, pp. 1505-1536

45 *The Developmental Cycle of the Bothriocephalus Latus. C. Janicki and F. Rosen.—p. 1505.
46 Avirulent Diphtheria-Like Bacilli. J. L. Burckhardt.—p. 1517.
47 *Roentgen Treatment of Disease of the Nails. L. Merian.—p. 1521.

45. **Development Cycle of Bothriocephalus.**—The research here reported has supplied the missing link in the development of the *Bothriocephalus latus L.* The larvae are eaten by the *Cyclops strenuus* and *Diaptomus gracilis.* These form the intermediate link, and as they are eaten by fishes, the parasite finds its way to man, dog and cat, and the cycle starts anew. Each of the five phases of the cycle may take up to three or four weeks. The work was done at the laboratories of the Universities of Lausanne and Neuchâtel.

47. **Disease of the Nails.**—Merian gives illustrations before and after roentgen treatment of slow pathologic processes in the matrix of the nails—onychia, usually traceable to some solution of continuity in the skin nearby. The results were excellent, the nail returning to normal without the disfigurement usual after such processes. One to three exposures answered the purpose. A single exposure proved effectual for one tuberculous process of the kind which had persisted for two years rebellious to various measures, including curetting and heliotherapy. The aspect of the thumb now seems quite normal. With psoriasis and eczema, he exposes the skin around to the usual eczema dose, but gives the nail matrix the deep dose, from 3 to 8 H, in one sitting.

Riforma Medica, Naples

October 13, XXXIII, No. 41, pp. 973-992

48 *To Free Convalescents of Typhoid Bacteria. L. Preti.—p. 973.
49 Dissociated Cortical Paralysis After War Wound and Localizations of Motor and Sensory Functioning. E. Salkind.—p. 974.

48. **Treatment of Bacilli Carriers.**—Preti noticed that the serum of patients convalescing from typhoid never contained agglutinins in any proportion when typhoid bacilli could still be found in their stools. This suggested that by artificially increasing the agglutinins it might be possible to free the men from the bacilli. He consequently gave a small injection of antityphoid vaccine. There was always a pronounced general reaction, and the typhoid bacilli disappeared from the stools thereafter. Although his experience is limited, the unfailing success justifies trials of this means of curing carriers of typhoid and possibly of other germs.

Rivista Critica di Clinica Medica, Florence

October 20, XVIII, No. 42, pp. 409-420

50 *Nervous and Functional Disordered Action of the Heart in Soldiers. N. Pende.—p. 409. Commenced in No. 38, p. 365.
51 Big Abdomen in Soldiers. S. Pisani.—p. 412. Continuation.

50. **Disordered Heart Action in Soldiers.**—Pende has found that all the purely nervous and functional heart disturbances which he has encountered in soldiers can be roughly classified in four groups: those with indications of excessive thyroid functioning; those with vagotonia; those whose hearts are not well developed and strong; those with symptoms deceptively simulating myocarditis. When the case can be ranged in one of these classes, the indications for treatment are apparent at once. For the thyroid group, bland local radiotherapy of the thyroid and galvanization of the thyroid and cervical sympathetics might be tried, supplemented by pluriglandular organotherapy. Or pituitary treatment might counteract the thyroid, or minute regulating doses of thyroidin. He warns, however, that even at the best—when myasthenia cordis can be excluded—the heart in these cases may become suddenly strikingly disordered, with crises of depression which might prove dangerous in active military service. There may be some infectious factor along with the excessive thyroid functioning—Simmonds, Faha and others have recently demonstrated degenerative lesions in the myocardium of persons who had had exophthalmic goiter during life.

The men with myasthenia cordis should be given only light duty not calling for muscular effort. The vagotonic type of disordered heart action gives the best prognosis; treatment should consist in moral suasion, diversion, graduated exercises, good food and fresh air and mild hydrotherapy. In his fourth group, the adynamic, pseudomyocarditis cases, hospital treatment and psychotherapy do not have the slightest effect. The men can be given specialist neurologic treatment for a time, but the best plan is to send them home at once on a long furlough.

Hospitalstidende, Copenhagen

October 17, LX, No. 42, pp. 1021-1048

52 *Trichinosis in Denmark. J. Fibiger.—p. 1021.

52. **Trichinosis in Denmark.**—Fibiger reiterates that the meat from even one hog with trichinae is liable to start an extensive epidemic, as occurred at Hedersleben where 337 persons were affected and 101 died. The measures for control of trichinosis in Denmark have shown their efficiency in late years not only in the great reduction of cases in man but also in the reduced infestation of dogs and cats with trichinae, which they acquire from swine and rats. Rats become infested from the hog most frequently of all. In 1904-1905 more than 3 per cent. of the necropsies at Copenhagen's public hospitals showed the presence of trichinae; in 1910 the proportion was only 0.6 per cent. The meat control inspection revealed from six to nine hogs with trichinae in 1911-1913; thirteen in 1914 but only one in 1915. During the two latter years however, 693 sides of salted meat imported from America were found to contain the trichina.

Ugeskrift for Læger, Copenhagen

October 18, LXXIX, No. 42, pp. 1715-1740

53 *Mastoid Operation Fatalities. G. V. T. Borries.—p. 1715.
54 Length of Sanatorium Courses. O. Helms.—p. 1721.

October 25, No. 43, pp. 1741-1776

55 Treatment of Scabies. L. Nielsen.—p. 1741.

53. **Mastoid Operation Fatalities.**—Borries relates that during the last ten years 1,108 mastoid operations have been performed in Mygind's service at Copenhagen, and 10.7 per cent. of the patients died. The ages ranged from 2 months to 76 years. In only fourteen of the total 119 deaths was the operation in itself probably responsible for the fatal outcome. This mortality, corrected, amounts to only 1 per cent. of the total 1,108 operations. In fourteen other cases, serious postoperative complications developed, but the patients recovered. The danger of complications does not seem to be any greater with total than with simple mastoid operations, but if meningitis does occur it is liable to be more serious with the total operation.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JULY-DECEMBER, 1917

The following journals have been abstracted in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Acta Scholae medicinalis universitatis imperialis in Kioto. Irregular. 1.50 yen. Tokyo.
American Journal of Anatomy. Bi-m. $7.50. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. William Wood & Co., 51 Fifth Ave., New York.
American Journal of Orthopedic Surgery. M. $4. 126 Massachusetts Ave., Boston.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore.
American Journal of Public Health. M. $3. 126 Massachusetts Ave., Boston.
American Journal of Roentgenology. M. $5. 67 E. 59th St., New York.
American Journal of Syphilis. Q. $5. C. V. Mosby Co., St. Louis.
American Review of Tuberculosis. M. $3. 2419 Greenmount Ave., Baltimore.
Anales de la Facultad de medicina, Montevideo. Bi-m. $2. Montevideo.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
Annales de médecine. M. 23 francs. Paris.
Annali d'igiene. M. 20 lire. Rome.
Annals of Medical History. Q. $6. Paul B. Hoeber, 67 E. 59th St., New York.
Annals of Ophthalmology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $5. J. B. Lippincott Co., 227 S. 6th St., Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Archives de médecine et de pharmacie militaires. M. 40 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Diagnosis. Q. $2. Rebman Co., 141 W. 36th St., New York.
Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
*Archives de médecine des enfants. M. 18 francs. Paris.
Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.
Archives médicales Belges. M. 18 francs. Paris.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 2 W. 45th St., New York.
Archives of Pediatrics. M. $3. E. B. Treat & Co., 241 W. 23d St., New York.
Archives of Radiology and Electrotherapy. M. $5. London.
Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.
Brazil-medico. W. 20 milreis. Rio de Janeiro.
Bristol Medical and Chirurgical Journal. M. 6s. Bristol.
British Journal of Children's Diseases. Q. $5. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $1.25. G. E. Stechert & Co., 151 W. 25th St., New York.
British Medical Journal. W. $10. London.
Bulletin de l'Académie de médecine. W. 20 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $3. Baltimore.
Bulletin of the Lying-in Hospital of the City of New York. Irregular. $1. 23 E. 93d St., New York.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. $0.25. 1211 Cathedral St., Baltimore.
Bulletins et mémoires de la Société médicale des Hôpitaux de Paris. W. 28 francs. Paris.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Medical Association Journal. M. $5. 386 Victoria St., Toronto.
Chirurgie degli organi di movimento. Bi-m. 35 lire. Bologna.
Cleveland Medical Journal. M. $2. 2318 Prospect Ave., Cleveland.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. W. 22 francs. Basel.
Cronica medica. Semi-m. 6 soles. Lima, Peru.
Delaware State Medical Journal. M. $1. Wilmington.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Escuela Médico-Militar. M. $4. Mexico City.
Gann. Irregular. Tokyo.
Gazzetta degli ospedali e delle cliniche. Semi-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago.
Indian Journal of Medical Research. Q. 10s. Calcutta.
Indian Medical Gazette. M. $5. Calcutta.
Journal de chirurgie. M. 44 francs. Paris.
Journal de médecine de Bordeaux. M. 15 francs.
Journal de médecine de Paris. M. 10 francs. Paris
Journal de radiologie et d'electrologie. M. 28 francs. Paris.
Journal of Abnormal Psychology. Bi-m. $4. R. G. Badger, 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. 810 State Bank Bldg., Little Rock, Ark.
Journal of Bacteriology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of Biological Chemistry. M. $3. 2419 Greenmount Ave., Baltimore.
Journal of Cancer Research. Q. $5. Williams & Wilkins Company, Baltimore.
Journal of Cutaneous Diseases. M. $5. W. M. Leonard, 101 Tremont St., Boston.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1. 334 St. James Bldg., Jacksonville, Fla.
Journal of Immunology. Bi-m. $5. Williams & Wilkins Company, Baltimore.
Journal of the Indiana State Medical Association. M. $2. 406 W. Berry St., Fort Wayne, Ind.
Journal of Infectious Diseases. M. $5. 629 S. Wood St., Chicago.
Journal of Iowa State Medical Society. M. $2. Des Moines.
Journal of Kansas Medical Society. M. $2. 303 Commerce Bldg., Topeka, Kan.
Journal of Laboratory and Clinical Medicine. M. $3. C. V. Mosby Company, St. Louis.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Harison Bldg., Augusta, Ga.
Journal of Medical Research. Bi-m. $4. 240 Longwood Ave., Boston
Journal of Medical Society of New Jersey. M. $2. 12 Cone St., Orange, N. J.
Journal of Michigan State Medical Society. M. $3.50. Power's Theatre Bldg., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3517 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $8. 64 W. 56th St., New York.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Parasitology. Q. $2. Urbana, Ill.
Journal of Pathology and Bacteriology. Q. $5.50. Cambridge, England.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of Pharmacology and Experimental Therapeutics. M. $5. 2419 Greenmount Ave., Baltimore.
Journal of South Carolina Medical Association. M. $2. Greenville, S. C.
Journal of Tennessee State Medical Association. M. $2. Doctor's Bldg., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal of Urology. Bi-m. $5. Williams & Wilkins Co., Baltimore.
Journal-Lancet. Semi-m. $2. 839 Lumber Exchange, Minneapolis.
Kentucky Medical Journal. M. $2. State and Twelfth Sts., Bowling Green, Ky.
Kitasato Archives of Experimental Medicine. Twice a year. 60 cents. Tokyo.
Lancet. W. $10. London.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. M. 15 francs.
Medical Journal of Australia. W. 6 d. Sydney.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medicine and Surgery. M. $3. Medicine and Surgery Publishing Co., Metropolitan Bldg., St. Louis.
Mental Hygiene. Q. $2. National Committee for Mental Hygiene, 50 Union Square, New York City.
Military Surgeon. M. $3.50. Seventh and B Streets, S. W., Washington, D. C.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität Kyushu. Irregular. Price varies. Fukuoka.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irregular. Price varies. Tokio.
Modern Hospital. M. $3. Metropolitan Bldg., St. Louis.
National Medical Journal of China. $2. 34 Nanking Road, Shanghai.
Nebraska State Medical Journal. M. $2.00. 468 Brandeis Bldg., Omaha.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Mexico Medical Journal. M. $2. P. O. 23, Las Cruces, N. M.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $1. 17 W. 43d St., New York.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
*Nourrisson. Bi-m. 14 francs. Paris.
Ohio State Medical Journal. M. $2. Physician's Bldg., Columbus, Ohio.
Ophthalmic Record. M. $4. 7 W. Madison St., Chicago.
Ophthalmology. Q. $5. 708 Cobb Bldg., Seattle, Wash.
Paris médical. W. 16 francs.
Pediatria. M. 20 lire. Naples.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Irregular. $3. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Prensa medica argentina. Semi-m. 25 francs. Buenos Aires.
Presse médicale. Semi-w. 15 francs. Paris.
Progrès médical. W. 12 francs. Paris.
Psychiatric Bulletin. Q. $2. New York State Hospital Commission. Albany.
Public Health Journal. M. $2. York Publishing Co., Lumsden Bldg., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Revista clinica. Q. $1. Medellin.
Revista de la Asociacion medica argentina. M. Buenos Aires.
Revista de medicina y cirurgia de la Habana. Semi-m. $4.50. Havana.
Revue de chirurgie. M. 33 francs. Paris.
Revue de médecine. M. 23 francs. Paris.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Rhode Island Medical Journal. M. $2. Providence.
*Riforma medica. W. 35.50 lire. Naples.
Rivista critica di clinica medica. W. 16 lire. Florence.
Rivista di clinica pediatrica. M. 18 lire. Firenze.
Russkiy Vrach. W. 13 rubles. Petrograd.
Sei-I-Kwai. M. $2. Tokio.
*Semana médica. W. $5. Buenos Aires.
Siglo medico. W. 20 pesetas. Madrid.
Southern Medical Journal. M. $3. 807 Empire Bldg., Birmingham, Ala.
Southwest Journal of Medicine and Surgery. M. $2. El Reno, Okla.
Southwestern Medicine. M. $2. El Paso, Texas.
Surgery, Gynecology and Obstetrics with International Abstract of Surgery. M. $10. Surgical Publishing Co., 30 N. Michigan Ave., Chicago.
Svenska Läkaresällskapets Handlingar. Q. 7.50 kronor. Stockholm.
Texas State Journal of Medicine. M. $1.50. Western National Bank Bldg., Fort Worth, Tex.
Tumori. Bi-m. 25 lire. Rome.
Ugeskrift for Læger. W. 20 kronen. Copenhagen.
United States Naval Medical Bulletin. Q. $1. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Irregular. 10 kronen.
Vermont Medicine. M. $1. Rutland, Vt.
Washington Medical Annals. Bi-m. $1. 2114 18th St., N. W., Washington, D. C.
West Virginia Medical Journal. M. $1.50. Huntington, W. Va.
Wisconsin Medical Journal. M. $2. Goldsmith Bldg., Milwaukee.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "B," "D" and "S." Matter pertaining to the Association is indexed under "American Medical Association."

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SOCIETIES

A.—Association.
Acad.—Academy.
Am.—American.
Coll.—College.
Conf.—Conference.
Cong.—Congress.
Conv.—Convention.
Dist.—District.
Hosp.—Hospital.
Internat.—International.
M.—Medical or Medicine.
Nat.—National.
Pharm.—Pharmaceutical.
Phys.—Physician.
Ry.—Railway.
S.—Society.
Surg.—Surgical, Surgeon or Surgery.

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2159-2256—	26	Dec. 29

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